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H.S. OFFICE OF STRATEGIC SERVICES
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MANUAL OF GERMAN
HEALTH SERVICES

Description

A description and interpretation of the health conditions, the resources in health personnel and facilities, and the organization and administration of health services in Germany. Appended to the text is a German-English glossary of common technical terms.

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Appended to the text is a glossary of the most common German technical terms and their American translations or their counterparts wherever literal translation would have little or no meaning.

It would be a hopeless undertaking to attempt a presentation of the subject matter which could satisfy both the specialist in a narrow field of health activity and the health administrator confronted with the gigantic task of putting a dilapidated administrative machinery back to useful work. No less difficult is the task of furnishing accurate information. Many of the facts and figures, intentionally or by force of circumstances, have been published in a way leaving much to be desired. Reliable information often refers to conditions which the health administrator may or may not find to be true in the area to which he is assigned.

The health administrator, then, faces a complicated task. A physically and mentally broken population will require emergency medical care to an extent likely to exceed the capacity of the available resources. A substantial number of such essential facilities as water treatment plants, sewage disposal systems, public health laboratories, hospitals, and clinics will be heavily

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ACCIDENTS (Unfälle).

Accidents constitute a major cause of absenteeism in industry and of disability among the working population, particularly among men. Since 1939 they have increased markedly, as a result of the introduction of new processes, long working hours, employment of unskilled labor, wear and tear on machines, and use of "ersatz" material.

Serious accidents had been steadily and rapidly declining up to the war, with the result that minor accidents were predominant. This trend has probably been reversed lately, although inclusive incidence figures are lacking.

In normal times, accidents in industry (Betriebsunfälle) and agriculture (landwirtschaftliche Unfälle) accounted for more than four-fifths of all accidents, and traffic accidents (Verkehrsunfälle), primarily motor car accidents, for most of the remainder. Accidents in transportation, falls, and injuries from machines constituted the largest single groups.

As a cause of death accidents were exceeded only by cancer (Krebs), apoplexy (Schlaganfall), pneumonia (Lungenentzündung), and old-age infirmity (Altersschwäche).

occurrence of an occupational disease on the official list must be immediately reported to designated administrative bodies, and a medical report must be submitted to the industrial physician employed by the state (staatlicher Gewerbeärzt), who has power to examine the patient or have him examined by an expert, if necessary.

Cash benefits are paid in case of temporary incapacity for work (Arbeitsunfähigkeit), permanent disability (Invalidität) (with the full pension set at two-thirds the previous annual earnings), and death. In the last case there are paid a funeral benefit equal to 15 percent of the annual wage but not less than 50 RM. and a survivors' pension, graded according to the number of children. There are additional benefits under special conditions. To prevent recurrence or an increase in severity of an occupational disease, the insured is urged to discontinue his work. He is offered a temporary pension ("Übergangsrente") designed to eliminate hardships.

The cost of the insurance is borne entirely by the employers, who must belong to one of the institutions set up under the plan. The levy on the

employers is graded according to the size of the establishments and the work hazards.

Administration of accident insurance is organized in either of two ways: (1) "Occupational associations" (Berufsgenossenschaften) are established for special types of industry or occupation, and are responsible for operation of the program; or (2) certain groups such as public authorities or the National Railway System (Reichsbahn) administer a program covering their own field of activity (Eigenunfallversicherung). All are public corporations. They are supervised by the central insurance office (Reichversicherungsamt) which is subordinated to the Reich Ministry of Labor (Reichsarbeitsministerium).

ADMINISTRATION, GENERAL (Allgemeine innere Verwaltung).

Under the Weimar Republic, Germany was composed of States (Länder) much like the United States. The National-Socialist regime, in line with its political aim of creating a national unified government, deprived these political units of such powers as they had possessed and made them administrative divisions of the Reich. All but two of the existing units were retained, with minor

boundary changes in some instances. To these states were added 11 new units (Reichsgaue) carved out of annexed territories, bringing the total number of units in 1944 to 26.

Prussia (Preussen) is the largest unit; Bavaria (Bayern) and the Reichsgaue Sudetenland, Danzig-West-preussen, and Wartheland are middle-sized; and the other units are comparatively small. Because of these differences, the administrative organization of the units below the Reich level varies.

In Prussia, the state government at present has hardly any significance as a separate unit, since it has been more or less absorbed by the Reich. Important administrative powers and functions are exercised by two types of authorities; those operating at the intermediate level (Mittelbehörden) and those operating at the local level (untere Behörden). Areas under the first group include (1) the provinces (Provinzen), headed by provincial presidents (Oberpräsidenten), and (2) subdivisions of provinces, the Regierungsbezirke which are headed by district presidents (Regierungspräsidenten). At the local level are some 400 rural counties (Landkreise) and urban counties (Stadtkreise), administered by

Leiters (Landräte for rural counties and Bürgermeister for urban counties). In Bavaria and the larger Reichsgaue there are either state governments or Reich governors (Reichsstatthalter) at the highest level, and government districts at the intermediate level, while provinces do not exist. In the smaller states and Reichsgaue, responsibility for general administration is centralized and vested in the state government or Reich governor.

ADMINISTRATIVE ORGANIZATION OF HEALTH SERVICE (Aufbau des Gesundheitswesens).¹

Legal responsibility for health service is divided between public agencies and social insurance organizations. In addition, voluntary health organizations are given a definite place in the administrative structure, and party organizations exert powerful influence on the organization and administration of health service.

The public agencies vested with administrative powers and functions in the field of health service include: (1) agencies operating at the local level (untere Instanz); (2) agencies operating at the

I. See Chart on page 12.

intermediate level (Mittelinstanz); and (3) agencies operating at the national level (Zentralinstanz).

At the local level administrative responsibility is concentrated in the health departments (See HEALTH DEPARTMENT) which cooperate with public agencies active in related fields, in particular the general welfare agencies (Wohlfahrtsämter) and child welfare agencies (Jugendämter) (See WELFARE, PUBLIC).

The localities (Gemeinden) are authorized by law voluntarily to establish, maintain, and administer such facilities and services for the community as are deemed necessary -- for example, hospitals or facilities for physical education and recreation -- and they must provide legally required facilities and services, such as water supply, sewage disposal, and smallpox vaccination. These are the so-called Selbstverwaltungsangelegenheiten. Furthermore the localities must carry out such functions as are delegated to them by law (Auftragsangelegenheiten): for example, the establishment, support, and administration of preventive health services.

In larger states such as Prussia, Bavaria, and Saxony, there are special administrative agencies, the

government districts (Regierungsbezirke), between the local and central agencies. These intermediate agencies have on their staffs medical administrators (Regierungs- und Medizinalräte), who are consultants to the administration in all matters pertaining to health, and are vested with supervisory powers over all local health activities. In Berlin the Regierungs- und Medizinalrat is attached to the President of the Police (Polizeipräsident). In eight Prussian districts, industrial physicians bearing the title Regierungs- und Gewerbemedizinalrat belong to the staff of the Regierungspräsident. The provincial presidents (Oberpräsidenten) in Prussia rely on the counsel of the medical administrators attached to the Regierungspräsidenten.

At the national level, authority for health service is divided among various ministries, as there is no health ministry. The Reich and Prussian Ministry of the Interior (Reichs- und Preussisches Ministerium des Innern) has a special division (Abteilung IV) for the direction of health work throughout the Reich. It is headed by a medical director with the rank of Ministerialdirektor and has a considerable staff of medical officers. (For details see REICH AND PRUSSIAN

MINISTRY OF THE INTERIOR). The Reich and Prussian Ministry of Labor (Reichs- und Preussisches Arbeitsministerium), in addition to being responsible for social insurance, is in charge of industrial hygiene (Gewerbehygiene), certain aspects of medical service by private practitioners, and medical care for war veterans (ärztliches Versorgungswesen). (For details see REICH AND PRUSSIAN MINISTRY OF LABOR). The Reich and Prussian Ministry of Education (Reichs- und Preussisches Ministerium für Wissenschaft, Erziehung und Volksbildung) is the highest authority responsible for universities (including medical schools), research institutions and physical education. The Reich Ministry of Economics (Reichswirtschaftsministerium) indirectly shares in responsibility for health service, having as one of its subordinate national offices the Reich Statistical Office (Statistisches Reichsamt) which is in charge of all health statistics as well as other statistics. (For details see REICH MINISTRY OF ECONOMICS).

The social insurance organizations play a most important role in the administrative structure. Social insurance is administered by special bodies, locally as

well as centrally. Thus medical care under social insurance is functionally and administratively separated from other services. (For details see SOCIAL INSURANCE, ACCIDENT INSURANCE, MINERS' INSURANCE, PENSIONS INSURANCE, AND SICKNESS INSURANCE).

Voluntary health organizations, including church and non-denominational organizations, are integrated into the system of public agencies. (For details see RED CROSS, REICH ADVISORY COUNCIL ON PUBLIC HEALTH, REICH MINISTRY OF THE INTERIOR, VISITING NURSE, and WELFARE).

The National-Socialist regime has added a fourth to the three types of agencies previously described: party organizations charged with responsibility for health activities. Of particular importance are: (1) the Hauptamt für Volksgesundheit led by the Reichsärztekreisführer and its subdivisions at the intermediate and local levels (Gauämter und Kreisämter), and (2) the Hauptamt für Volkswohlfahrt with subdivisions at the intermediate and local levels. Each of these organizations also has a health office (Amt für Volksgesundheit).

AUFBAU DES GESUNDHEITSWESENS*

(Administrative Organization of Health Service)

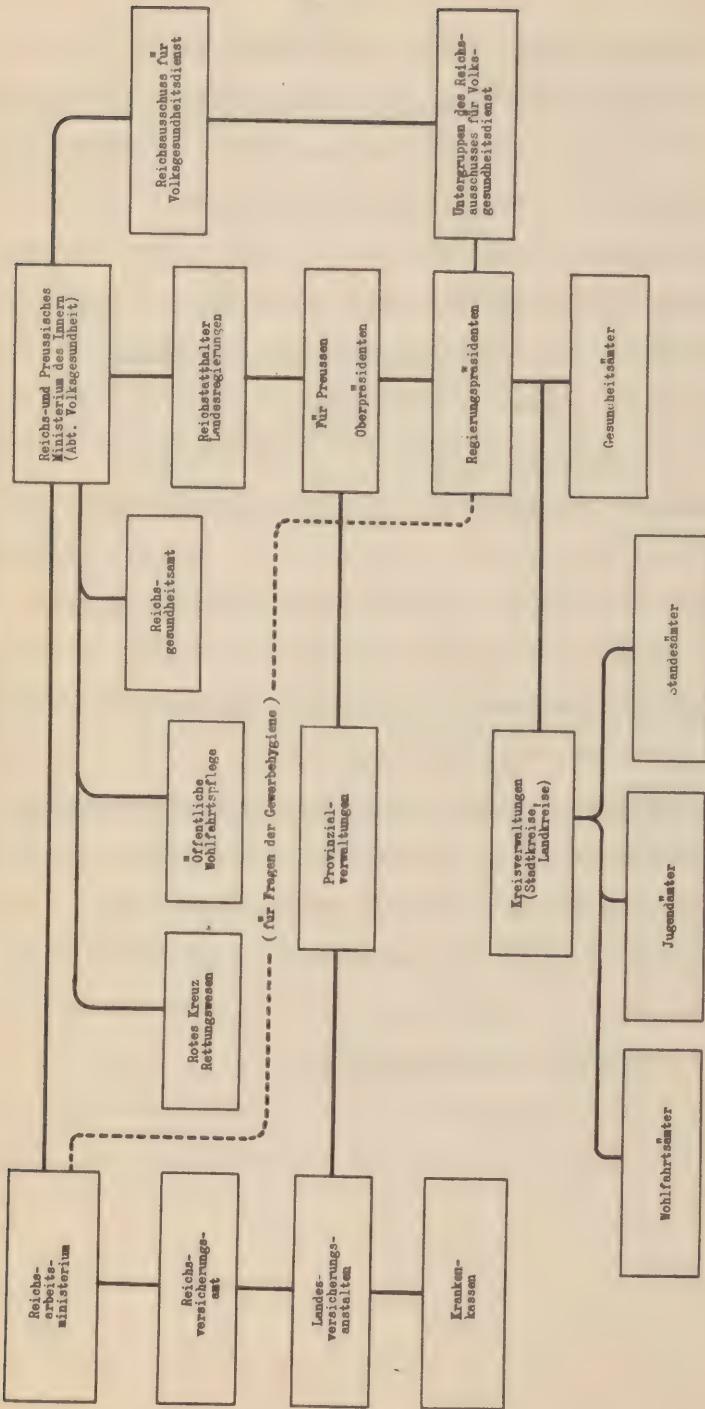


Chart 12. Civilized chart. Omitted are several agencies and details not of primary interest to the administrator. For details see Administrative Organization of Health Service.

AGE DISTRIBUTION (Altersaufbau).

The age distribution of the German population has undergone profound changes during the last decades. Before the war, children under 15 years of age constituted approximately one-fourth of the total population in contrast with 1910 when their proportion exceeded one-third. The so-called "productive age group" from 15 to 65 years accounted for nearly seven-tenths of all before the war as against little more than six-tenths in 1910. Approximately one-fifteenth of the population in 1939 was 65 years of age or older as compared with one-twentieth in 1910.

To what extent war casualties among the soldiers and civilians, rising mortality from disease and injury, and marked fluctuation in the birth rate may have altered the age distribution cannot be estimated. However, the figures given above may still be useful as a "working tool" in making plans for the prevention of the spread of communicable diseases predominant in certain age groups -- in particular the common communicable diseases of childhood -- and for the organization of emergency medical care.

AMBULANCE SERVICE (Krankenbeförderung).

Many of the larger cities and some counties operate a public ambulance service, while others support voluntary organizations active in the field, primarily the Red Cross (Rotes Kreuz).

Public ambulances (Krankenwagen) are stationed at hospitals or first-aid centers (Rettungssämter, Rettungswachen). Some of the Rettungssämter also direct the proper distribution of patients to the various hospitals on the basis of daily reports of free beds. Often the fire stations (Feuerwehrwachen) arrange for transportation of the sick. In many parts of the country the Red Cross maintains a fleet of ambulances. Most of the large industrial corporations possess ambulance services of their own. (See also FIRST-AID SERVICE and RED CROSS).

ANTHRAX (Milzbrand).

Anthrax in man is mainly an occupational disease occurring among persons employed in certain industries and trades, such as tanning, bristle manufacturing, and the rag trade. The majority of the cases before the war were caused by infected material imported from foreign

countries. The total number of reported cases, however, was small: 145 in 1930, and 90 in 1935. During the war, anthrax has become rarer as a result of the cessation of imports of skins and bristles. In 1930, 1935, and 1940 there were 11, 10, and 15 deaths respectively from anthrax.

The control of anthrax in man rests first of all on measures for the control of this disease in animals. The basic Reich law dealing with communicable animal diseases, the Reichsviehseuchengesetz, requires reporting of animals with anthrax and destruction of corpses (Vernichtungszwang für Kadaver). Immunization (Schutzimpfung) is applied widely. Furthermore, the disinfection of imported bristles, skins, and similar material, and the use of protective clothing (Schutzkleidung) in hazardous industries are emphasized. (See also INDUSTRIAL HYGIENE).

ATTENDANT, MEDICAL (Heilgehilfe).

The auxiliary health personnel (ärztliches Hilfspersonal) available in Germany includes among many other groups the following: Bader, Heilgehilfen und Masseure, and Krankengymnastinnen.

The Bader, comparable to the old-time barber-surgeons, are found mainly in rural areas and particularly in Bavaria. In 1939, there were 1,403 Bader possessing an official certificate (staatliche Anerkennung) which indicated that they had received elementary training in first aid and simple technical and nursing procedures. Many operated barbershops (Friseurgeschäfte).

The Heilgehilfe and the Masseur represent a somewhat higher grade of medical attendant, the latter being widely used for giving massages. Of a total number of 10,112 persons classified in this group in 1939, only some 5,000 had completed an elementary training of several months and were officially certified (staatlich anerkannt).

The Krankengymnastin is a woman with special training in gymnastic exercises for sick people, massage, and physical therapy. In some parts of the country, such as Saxony (Sachsen) the training of Krankengymnastinnen is well organized and extends over a period of 18 months. The total number of Krankengymnastinnen before the war was about 1,000.

All three groups are under the general supervision of the health officer (Amtsarzt). (See also HEALTH DEPARTMENT and HEALTH OFFICER).

BANG'S DISEASE, UNDULANT FEVER (Bangsche Krankheit,
Undulierendes Fieber).

Bang's disease has been notifiable throughout the Reich since the end of the 1930's only. Reported cases totalled 327 in 1939; 264 in 1940; 229 in 1941; and 202 in 1942. Because of the difficulty of establishing the diagnosis of Bang's disease, the official figures must be accepted with reservations. Deaths from Bang's disease numbered 7 in 1939; 9 in 1940; 10 in 1941; and 1 in 1942.

BATHING FACILITIES, PUBLIC (Offentliches Bäderwesen).

The shores of the numerous lakes and the river banks are dotted with public bathing facilities (Freibäder), widely used by people from all walks of life. Operation of such establishments is subject to local ordinances concerning location, booths, privies, first-aid equipment, etc., and -- under certain circumstances -- to bacteriological water tests. In recent years, sanitary conditions in the Freibäder have deteriorated greatly.

Most of the larger cities have long maintained more or less elaborate bathing facilities (Badeanstalten) with swimming pools (Schwimmbäder), showers (Brausebäder),

and tubs (Wannenbäder). These facilities are available to everybody at low rates. Their establishment and operation are regulated by local ordinances. Before the war, the water in swimming pools was usually chlorinated. Lack of essential chemicals has probably resulted in discontinuation of this practice. A considerable number of cities have showers installed in school buildings. In München, for instance, more than 50 schools possessed such equipment.

Supervision of all public bathing facilities from the hygienic point of view is one of the functions of the health officer (Amtsarzt), and is carried out by regular inspections.

BIRTHS (Geburten).

For many decades the live birth rate (Lebendgeburtenziffer) has declined markedly, although not without interruptions. It was 35.6 per 1,000 population in 1900, 17.6 in 1930, and 20.0 in 1940. Significantly, the curve showed a strongly rising tendency in the years following the conclusion of the war of 1914-1918, only to fall again later. It went up from a low of 15 during the depression years of the early 1930's to 20 in 1940,

but declined thereafter to about 16 or 15 in spite of the efforts of the Nazi regime to stimulate confidence in its future and the "Wille zum Kinde".

The excess of births over deaths (Geburtenüberschuss) declined from 13.6 per 1,000 population in 1900 to 6.5 in 1930 and 7.3 in 1940, although it rose temporarily during the thirties. Lately, the excess of births over deaths has been slight. (See also INFANT MORTALITY and MORTALITY).

Male births usually exceed female births. Illegitimate births (uneheliche Geburten) accounted for 8 to 12 percent of all births during the 1930's, and were particularly frequent in communities of under 2,000 population. (For details see ILLEGITIMACY). Before the war, the birth rate was relatively lower in cities with over 100,000 population and highest in communities of less than 2,000.

For many decades still births (Totgeburten) accounted for approximately 3 percent of all births. Only since about 1930 has their proportion markedly declined.

BIRTH CONTROL (Geburtenregelung).

Prior to the Nazi regime, contraceptive methods

(empfängnisverhütende Mittel) were employed widely, particularly by the urban population and persons in the middle and higher income groups. Medical prescription of contraceptives and their sale over the counter were legally allowed. However, the law declared it a punishable offense publicly to announce, advertise, or display devices "for immoral purposes". Accordingly, prosecutions were confined to such violations. In a number of cities public or voluntary consultation centers were maintained where advice on birth control was given and devices were distributed when indicated.

The Nazi regime has done everything in its power to suppress the birth control movement as inimical to the population policy of the Third Reich. By decree of 20 January 1941 the manufacture and sale of various devices widely used for prevention of pregnancy or induction of artificial abortion were prohibited, and physicians were forbidden to apply any method of treatment that might result in abortion, except in legally authorized cases.

CANCER (Krebs).

The crude death rate from cancer before the war was between 140 and 150 per 100,000 population.

In Germany, as in many other countries, cancer has become the second most frequent cause of death, exceeded only by heart conditions. (See also MORTALITY.) The major reasons for this development are: (1) a considerable increase in the average length of life with a resultant change in the age distribution of the population; (2) improvement in the accuracy of diagnosis -- significantly, deaths classified as caused by old-age infirmity (Altersschwäche) have been declining markedly; and (3) the reduction of diseases rampant in earlier times. Extensive statistical studies, based on standardized death rates, have furnished no convincing evidence of a real increase in cancer.

The Weimar Republic, early in the 1930's, established a Reich Committee for the Campaign against Cancer (Reichsausschuss für Krebsbekämpfung), which under the Nazi regime was incorporated into the Reich Advisory Council on Public Health. The recommendations of this committee concerning the organization of a nation-wide cancer control program cover all aspects of the problem. In

actual practice, organized programs have made slow progress, as the Nazi regime has been preoccupied with fields of health service directly related to the preparation of the nation for war.

Prior to 1939, the university hospitals and many of the general hospitals maintained by public or non-governmental agencies were well equipped for the surgical and roentgenological treatment of cancer, and a few possessed quantities of radium sufficient for treatment of large numbers of patients. Special clinics for case finding and follow-up were not conducted. Instead, the services of the nurse-midwives, visiting nurses, and medical social workers in the districts were utilized for this purpose.

CHILDBED ATTENDANT (Wochenpflegerin).

The Wochenpflegerin is a nurse -- midwife's aide, to attend women in the postnatal period. By Reich decree of 7 February 1943 the training of this type of auxiliary health personnel has been uniformly regulated. Training must be taken at an approved school, usually an institution providing for the professional education of midwives, and must be completed by examination and graduation. Only women who

have satisfied these requirements and received an official certificate (staatliche Anerkennung) are allowed to engage in the occupation of childbed attendant.

The total number of Wochenpflegerinnen is relatively small. Between 1,300 and 1,500 childbed attendants were officially reported in the years preceding the war, the majority practicing in urban areas of Prussia. Their number probably has not changed significantly since. Childbed attendants are guaranteed a minimum annual income of 1,200 RM. per year, according to the law of 1943. Their activities are carried out under the general supervision of the health officer (Amtsarzt).

The close relationship of childbed attendants and midwives is stressed by the requirement that both belong to the same national organization, the Reich Association of Midwives (Reichshebamenschaft).

CHILDREN'S NURSE (Sauglings- und Kinderschwester).

An official permit is required for persons who want to engage in the occupation of children's nurse, and such permit is given only if the requirements for

registration as graduate children's nurse (staatlich anerkannte Säuglings- und Kinderschwester) are satisfied. The conditions to be met are essentially those for registration as general nurse (see NURSE), except that the 18 months of training must be taken at a special school, the staatlich anerkannte Säuglings- und Kinderpflegeschule. On successful completion of the course and subsequent state board examination, the nurse is eligible for a permit to practice in any part of the Reich. However, the permit as such entitles her to work in children's hospitals only. To take up private duty nursing or to obtain a position outside a hospital, the graduate children's nurse must complete at least 6 months of practical work in an approved children's hospital and an additional 6 months of service with a preventive clinic for children.

The major functions of the children's nurse are (1) bedside nursing of the prematurely born and of sick infants and children, and (2) assistance at sessions of wellbaby conferences and similar preventive services.

The decree containing these stipulations was issued in November 1939 and superseded regulations

dating back to 1930. The earlier regulations distinguished between children's nurses who were obliged to take a two-year training, and so-called Säuglings-
und Kleinkinderpflegerinnen, i.e., persons who received one year of training in health care of well babies and small children, handling of minor sickness cases, and aid to the housewife in housekeeping. Training of the latter group was discontinued as of September 1940. However, persons formerly licensed for this type of work were not forbidden to practice as before.

Before the war there was a total of about 11,000 children's nurses. Of these, 42 percent were registered graduate Schwestern, and 32.4 percent registered graduate Pflegerinnen, while 25 percent were in practice without having met the official requirements.

CHRONIC DISEASE HOSPITAL (Pflegeanstalt, or Pflegeheim, also called Siechenhaus).

One of the characteristics of the German hospital policy is the emphasis placed on public hospitals and hospital-like institutions for the care of chronically ill and seriously disabled persons. In 1939, there

were more than 23,000 beds in 124 chronic disease hospitals. Many of these institutions are maintained by large administrative units, the Landesfürsorgeverbände, rather than by the local units of government. Some are owned by large cities. Paying patients are accepted but constitute a negligible fraction of the total. (See also WELFARE, PUBLIC).

CLINIC, PREVENTIVE (Fürsorgestelle or Beratungsstelle).

The preventive clinic is the center of direct health service to the individual. The large majority of these institutions are maintained by local units of government. Of the rest, most are supported by the invalidity insurance system (Landesversicherungsanstalten), and a relatively small proportion by voluntary organizations.

In a number of large cities, a variety of clinics are housed in health centers. In other cities and in smaller communities space in the health department building or in hospitals, or property owned by the locality (Gemeinde) is utilized for the accommodation of clinics. Modern healthmobiles for service to rural areas are uncommon. However, before the war

the rural districts in many counties were regularly visited by teams of physicians, or dentists, and public health nurses.

The most frequent types of preventive clinics are: (1) the maternal and infant health clinics (Schwangerenfürsorgestellen und Säuglingsfürsorgestellen, the latter also called Mütterberatungsstellen), many of which extend their services to children of pre-school age (Kleinkinder); (2) school health clinics, in particular, the dental clinics for school children (Schulzahnkliniken); (3) tuberculosis clinics (Tuberkulosefürsorgestellen); (4) venereal disease clinics (Beratungsstellen für Geschlechtskranke); and (5) racial hygiene clinics (Beratungsstellen für Erb- und Rassenpflege). The last are an innovation of the Nazi regime, while the first four types were developed on a large scale after the First World War. Some of the clinics existing at the time of the Weimar republic, in particular the birth control and sex hygiene clinics, were abolished by the Nazi regime; others, such as the comparatively highly developed crippled children's clinics (Krüppelfürsorgestellen), received but scant attention. The mental hygiene clinics, in process of development prior to 1933, are no longer mentioned in

official publications.

As a general rule each clinic is staffed with one or more physicians, several public health nurses, and clerical personnel, the number of these persons depending upon the case load. The majority of the physicians are employed on a part-time salaried basis. Large cities often have a full-time system of medical service.

The preventive clinic is "the arm of the health department", and its work is carried out under the general supervision of the health officer (Amtsarzt), according to standards set by the higher authority. (For details see BIRTH CONTROL, CANCER, CRIPPLED CHILDREN'S PROGRAM, HEALTH DEPARTMENT, INFANT HEALTH SERVICE, MATERNAL HEALTH SERVICE, MENTAL HYGIENE CLINIC, OUT-PATIENT DEPARTMENT, RACIAL HYGIENE, SCHOOL DENTAL PROGRAM, TUBERCULOSIS CONTROL, and VENEREAL DISEASE CONTROL).

COMMUNICABLE DISEASE CONTROL (Bekämpfung übertragbarer Krankheiten).

The control of communicable diseases follows a definite pattern which has gradually evolved since 1900

when the first nation-wide law was passed. The principles which had been adopted, although not uniformly applied, by the states prior to 1933 were recodified and made mandatory for the Reich in a law of 1 December 1938.

Cornerstones of the control program are:

(1) compulsory reporting of most -- although not all -- communicable diseases (see REPORTABLE DISEASES);
(2) epidemiological investigation (Ermittlung der Krankheit) and observation (Beobachtung) which are duties of the health officer (Amtsarzt); (3) free diagnostic service by public health laboratories (see LABORATORY, PUBLIC HEALTH); (4) legally prescribed preventive measures (Schutzmassnahmen) as summarized below; and
(5) a legal requirement for the localities (Gemeinden) to establish and maintain such facilities and services as are necessary for the control of communicable diseases.

Preventive provisions include (1) authorization of the Amtsarzt to visit a patient in his home to take tests, usually with the consent of the attending physician and in some cases without it; (2) required treatment (Behandlungszwang), when necessary, for persons in an

infectious stage; (3) compulsory isolation (Absonderung) in a hospital -- usually the infectious ward of a general hospital -- if segregation of the sick in the home is not feasible; (4) performance of autopsies (Leichenöffnungen) on the request of the Amtsarzt, if deemed necessary; (5) quarantine of contacts; (6) plarding of houses (kenntlich machen) if indicated; (7) current and terminal disinfection (laufende und Schlussdesinfektion); (8) exclusion of carriers from any occupation in the food trade which may involve the spread of infection; and (9) closing of schools (Schulen) and public-bathing facilities (Badeanstalten), and prohibition of public gatherings, in particular of public markets and fairs (Öffentliche Märkte und Messen), in times of epidemics.

All control measures are taken on the advice of the Amtsarzt and are supervised by this official. (See also ANTHRAX, DIPHTHERIA, DISINFECTOR, DYSENTERY, FOOD CONTROL, HEALTH OFFICER, HOSPITAL, LABORATORY, LICE, MORBIDITY, OPHTHALMIA NEONATORUM, PARATYPHOID FEVER, RABIES, RELAPSING FEVER, REPORTABLE DISEASES, SCARLET FEVER, SCHOOL HEALTH SERVICE, SMALLPOX VACCINATION, TRACHOMA, TRICHINOSIS, TUBERCULOSIS CONTROL, TYPHOID

FEVER, TYPHUS FEVER, VENEREAL DISEASE CONTROL, and WHOOPING COUGH.)

CONVALESCENT HOME (Genungsheim, Erholungsheim).

Institutions of the convalescent home type are numerous. They are used extensively not only for the treatment of convalescents and patients with minor illness, but also to strengthen the resistance of children and adults on the borderline between health and sickness. These institutions are generally located at the seashore, in the mountains, or in the country at a considerable distance from cities.

A fairly large number of convalescent homes are maintained by organizations in charge of social insurance, primarily by pension insurance administrations, another substantial number by cities and counties, and the rest by voluntary organizations and individual entrepreneurs.

Persons covered by social insurance receive care in convalescent homes at the discretion and expense of the social insurance bodies responsible. Children and -- to a lesser degree adults -- with small or no means are sent away (verschickt) to homes by cities

and counties at low rates or free of charge. The National-Socialist Welfare Organization (N.S. Volkswohlfahrt) has placed much emphasis on the organization of so-called rest cures (Erholungsverschickung) for self-supporting persons. The German Labor Front (Deutsche Arbeitsfront) has sponsored "Erholungswerk" for industrial workers. The organization called Hilfswerk "Mutter und Kind" provides for the convalescent care of women after delivery (Müttererholungsfürsorge).

All institutional facilities classified under the general heading "convalescent home" are supervised by the health officer in charge of the district in which the home is located.

CRIPPLED CHILDREN'S PROGRAM (Krüppelfürsorge).

According to the Reich decree concerning public welfare, adopted 13 February 1924 (Verordnung über die Fürsorgepflicht), the agencies responsible for public welfare are required to provide needy persons with medical care (Krankenhilfe) and service to restore working ability (Wiederherstellung der Arbeitsfähigkeit). In the case of children, public aid also includes

education and such services as are necessary to make the child capable of earning a living (Erwerbsfähigung). (See also WELFARE, PUBLIC.)

In addition to the nation-wide welfare law, state laws or decrees concerning crippled children's programs are in effect in most parts of the country. Although they differ in detail, they follow the general pattern set in 1920 by Prussia in its crippled children's law (Gesetz betreffend die öffentliche Krüppelfürsorge). This law requires the reporting of any crippling condition (vorhandene Verkrüppelung) and of any condition which may result in crippling (drohende Verkrüppelung). The report is to be filed with the county child welfare department (Kreisjugendamt) which maintains a master file of all cases in its district, the so-called Krüppelstammliste. The cornerstone of the control program is the crippled children's clinic (Krüppelfürsorgestelle), maintenance of which is mandatory. This clinic is responsible for formulating an overall treatment plan (Entkrüppelungsplan). The health department decides on and supervises the medical aspects, while the child welfare department foots the bill for medical care and provides for needed educational and vocational services, if the parents are unable to pay. In contrast to other

services received at public expense, rehabilitation service is exempted from recovery of costs (nicht ersatzpflichtig). To some extent the sickness insurance organizations (Krankenkassen) used to share in the service for crippled children by providing for certain appliances and subsidizing or furnishing preventive services. This activity probably has more or less ceased in recent years.

Crippled children's programs reached a high level under the Weimar Republic, but have been more and more curbed by the Nazi regime in line with its ideas on the value of human beings.

DENTAL CARE (Zahnpflege).

The organization of dental care in Germany is hard to understand because of (1) the multitude of agencies concerned, (2) the differences in type and scope of dental care available under various programs, and (3) the existence of two types of dental personnel, dentists (Zahnärzte) and dental technicians (Dentisten), whose activities are complementary. (For details on personnel see DENTIST and DENTAL TECHNICIAN.)

Many of the larger cities and a number of counties support an organized program of dental care for school children (Schulzahnpflege), an activity which started on a small scale several decades ago. The principal feature of these programs is the regular mouth inspection of all children in certain grades, followed by immediate correction of all defects discovered. The service is tax-supported and available to all children who attend schools participating in the program. (For details see SCHOOL DENTAL PROGRAM.)

Many cities and counties provide for emergency dental care for needy persons, either through public clinics (zahnärztliche Poliklinik) or by paying dental

personnel in private practice.

The organizations administering sickness insurance (Krankenversicherung), accident insurance (Unfallversicherung), and pension insurance (Invalidenversicherung, Angestelltenversicherung) allocate considerable sums for the payment of dental services rendered to insured persons. Sickness insurance organizations (Krankenkassen), which are legally responsible for provision of service necessary to the treatment of illness (Behandlung von Krankheiten), pay for such dental care as falls under the legal definition, "treatment of illness". In actual practice, fillings and extractions are the services most frequently paid for by the Krankenkassen. It must be noted that determination of the extent to which fillings are allowed in the individual case is left to the discretion of the Krankenkasse. Prior to the advent of the Nazi regime, a considerable number of Krankenkassen maintained well-equipped and well-staffed dental clinics of their own which furnished good and economical service.

Utilizing an authorization in the Reich Insurance Code (Reichsversicherungsordnung) to make expenditures

for the prevention of premature permanent disability (Invalidität), the various organizations in charge of pension insurance take over part of the cost of bridges, dentures, and similar devices referred to as Zahnersatzmittel, the patient paying the rest of the bill. Organizations administering accident insurance, the Berufsgenossenschaften, have been particularly liberal in providing for complete dental care as part of their vocational rehabilitation service.

During the war, dental service for civilian adults has been severely curtailed because of lack of personnel and material. Only emergency service has been continued, and that on a limited scale. On the other hand, not only members of the armed forces, including the party formations, but also the police force receive all dental care needed. Dental clinics mounted on railroad cars are used to bring dental service to police in outlying districts.

In 1943, the Nazi regime founded a Reich Committee for the Prevention of Dental, Mouth, and Jaw Diseases (Reichsausschuss zur Verhütung von Zahn, Mund und Kieferkrankheiten). This committee does nothing to compensate civilians for the absence of anything

resembling reasonable dental service.

In view of the many years of neglect of dental care, a heavy demand for the treatment of carious teeth must be anticipated in the near future.

DENTAL TECHNICIAN (Dentist).

Dental technicians constitute a group of persons with practical training but without university education in dentistry. Their functions are restricted by law. Treatment of jaw and mouth conditions (Mund- und Kieferkrankheiten), for instance, is a monopoly of dentists or oral surgeons. (See DENTIST.)

Minimum standards of service by dental technicians are maintained through the approval system. Dental technicians who, after completion of three years of apprenticeship with a dentist or dental technician of high standing and several years of practical work, have passed a state-board examination receive a certificate (Ausweis) entitling them to practice within the limits set by the law. They are called staatlich geprüfte Dentisten. At the end of the 1930's, nearly three-fourths of all dental technicians possessed such certificates, while one-fourth did not meet the official requirements but were nevertheless "in business".

Before the war, dental technicians numbered about 21,000 or one for every 3,330 persons. More than 10 percent were women. Many practiced in small communities. Dental technicians were more numerous than dentists: in 1939, there were 139 dental technicians to every 100 dentists, and in rural areas about two dental technicians to every dentist. More than four-fifths of all dental technicians served persons covered by social insurance against sickness. They derived the greater part of their income from payments by sickness insurance organizations (Krankenkassen). Like all other health personnel, dental technicians are under the general supervision of the health officer (Amtsarzt).

The national organization of the dental technicians is the Reichsverband Deutscher Dentisten which, unlike the organization of the dentists, is not a public law corporation with compulsory membership.

DENTIST (Zahnarzt).

Dentists are professional persons with university education (Hochschulbildung). Their professional training extends over 7 semesters -- three

preclinical and 4 clinical. It is concluded by a final examination (Staatsexamen), successful completion of which entitles the candidate to a license to practice dentistry in any part of the Reich.

Before the war, there were about 15,000 licensed dentists in Germany, or one for every 4,550 persons, with women accounting for 9 percent of the total. Their distribution was very uneven. In rural areas the number of dentists per unit of population was less than half of that in cities. In the late 1930's, the number of dental students declined sharply, which indicates a shortage of dentists may be expected in the immediate future. However, in appraising the situation, it must be borne in mind that there is another numerically strong group of persons engaged in furnishing dental care, namely, the dental technicians (Dentisten), whose training and functions differ from those of the dentists. (For details see DENTAL TECHNICIAN.)

Approximately two-thirds of all dentists are health insurance dentists (Kassenzahnärzte), and an additional small fraction are admitted to substitute funds only (Ersatzkassenzahnärzte). Thus, the majority of the dentists obtain a substantial income, if not the greater

part of their revenues, from payments made by the sickness insurance organizations (Krankenkassen).

The national organization of dentists is the Reich Chamber of Dentists (Reichszahnärztekammer) to which all dentists must belong.

DIABETES (Zuckerkrankheit).

Estimates of the prevalence of diabetes placed the total number of cases at about 250,000 in 1940. It may be assumed that a substantial number of diabetics were persons in the higher age groups, whose needs could be easily met under normal conditions.

Sample studies of persons covered by compulsory sickness insurance have shown that, under pre-war conditions, there were 62 cases of diabetes per 100,000 insured men and 79 cases per 100,000 insured women in the productive age groups. The average duration of a case of disability due to diabetes was about 57 days. Prior to the war, the number of deaths from diabetes per 100,000 persons was 15 in the case of men and 21 in the case of women.

The war has probably changed the picture. Insulin rationing by the coupon system (Insulin-

bezugskarte) was introduced in 1942, but the supply of insulin seems to have dwindled rapidly. At the end of 1943, official advices urged the diabetics to "adapt" themselves to the food rations available, i.e., a diet poor in protein and fat but rich in carbohydrates. Judging from the experience of the First World War, a goodly number of diabetics may have died as the result of insulin shortage and improper diet.

DIPHTHERIA (Diphtherie).

Diphtheria is reportable by law throughout Germany. In normal times as well as during the war it has been one of the most common communicable diseases, along with venereal diseases and measles. In a considerable number of recent years diphtheria either led all other reportable diseases in frequency, or ranked second only to scarlet fever. Reported were 70,552 cases in 1930; 133,843 in 1935; 174,052 cases in 1940; and approximately 300,000 cases in both 1942 and 1943. The number of reported cases per 100,000 population has increased from 110 in 1930 to 200 in 1935, 193 in 1940, and more than 310 in 1943. Thus, in recent years the rate has been two to three

times higher than in the U.S. There has been no consistent pattern in the regional distribution of cases.

The number of deaths rose from 4,534 in 1930 to 6,304 in 1935, 8,500 in 1940, 9,607 in 1941, and about 15,000 in 1942, or from 7 per 100,000 population to 9.5, 9.5, 11 and 16 respectively. In the early 1940's the German death rate from diphtheria was 10 to 16 times as high as that in the U.S. During the period from 1930 to 1942, the case fatality ranged from 4.6 to 6 per 100 reported cases of sickness.

Control of diphtheria is based on the general principles discussed under COMMUNICABLE DISEASE CONTROL, and on a series of specific measures which, however, are not applied uniformly. They include, (1) active immunization (Schutzimpfung) with toxoid or toxin-antitoxin, recently strongly emphasized but not mandatory, and (2) regulations concerning the prevention of diphtheria in schools, homes for children, day nurseries, and similar institutions.

Regulations for the prevention of diphtheria in schools, while not identical in all parts of Germany,

follow principles laid down in the Preussische Anweisung vom 22 September 1927 (Preussischer Schulseuchenerlass).

Teachers, pupils, and personnel employed in a school are forbidden to enter the school building when they are sick, are carriers, or are exposed to infection in their homes. They are allowed to resume their duties only after the possibility of a spread is eliminated. A medical certificate to this effect and at least three negative bacteriological tests, taken at two-day intervals, are required. Admission of carriers to school may be allowed not earlier than 8 weeks after the disappearance of clinical symptoms. Schools may be closed and reopened by the health officer (Amtsarzt).

Children must not be sent to sanatoria, convalescent homes, camps, spas, etc., unless a bacteriological test has been taken. All persons employed in children's homes must be examined to eliminate carriers.

DISINFECTOR, EXTERMINATOR (Desinfektor, Kammerjäger).

Disinfectors and exterminators are employed by public agencies for two main purposes: (1) to carry

out the current and terminal disinfection (laufende und Schlussdesinfektion) of homes and institutions in cases of infectious disease, the so-called Entkeimung, and, (2) to exterminate insects, a procedure called Entwesung, popularly Entlausung or Entwanzung as the case may be. Many cities maintain special institutions complementing the work of the disinfectors and exterminators, the so-called Desinfektionsanstalten.

The personnel is trained in special state-approved institutions, the staatlich zugelassene Desinfektorenschulen, most of which are affiliated with other training centers. A training in theory for 2 weeks (somewhat less in some instances) is followed by 4 weeks of practical field work. On successful completion of the training, the candidate is registered as state-approved disinfector (staatlich geprüfter Desinfektor). Refresher courses must be taken every six years.

Before the war there were about 6,000 disinfectors, of whom 12 percent were women. In urban areas they were usually employed full-time by the city governments, in rural areas they served not infrequently

on a part-time basis. Their supervision and reexamination every three years are functions of the health officer (Amtsarzt). (See also COMMUNICABLE DISEASE CONTROL and HEALTH OFFICER.)

DISPOSAL OF THE DEAD (Leichenwesen).

The disposal of the dead is regulated by a large number of statutes, nation-wide laws as well as local ordinances. It is supervised by the health officer (Amtsarzt).

Inspection of the body to ascertain death and notification of the police are mandatory. Certification by a physician, including determination of the cause of death, is strongly urged, but not at all a general practice. Particularly in sparsely settled areas, but also in a number of cities, lay persons who meet certain legal qualifications perform the function of inspection (Leichenschau). The death certificates are submitted to the Amtsarzt, who either states that he has "no objections" to burial, or takes such action as is necessary to eliminate any doubts about the case.

Autopsies (Leichenöffnungen) are subject to the

consent of the family. However, they may be ordered against the will of the survivors, either by police (advised by the health officer) for reasons of public health, or by the court for reasons of public interest.

Transportation of corpses (Leichenbeförderung) is regulated by strict rules concerning coffins and vehicles, particularly in cases of communicable disease. Transportation of a corpse from one community to another requires a permit (Leichenpass).

Interment (Beerdigung) is allowed in cemeteries (Friedhöfe) only. Burial grounds must meet detailed requirements and be approved by the health officer who is also charged with their supervision.

Cremation (Feuerbestattung or Einäscherung) is contingent upon medical inspection of the dead, and crematoria are supervised by the health officer. The method of cremation has been shockingly abused by the Nazi regime to dispose quickly and without trace of the corpses of "enemies of the National-Socialist state".

Exhumation (Ausgrabung) and the transfer of corpses from one place to another (Umbettung)

require authorization by the local police and a certificate from the health officer.

DRUGS AND DRUG TRADE (Arzneimittel und Arzneimittelverkehr).

The pharmaceutical industry in Germany was highly developed before the war. It was one of the important export industries. Because of this situation, Germany was able during the first years of the war not only to meet her own vastly increased demand, but also to continue exports in order to accumulate foreign exchange. In these years, the large stocks accumulated prior to 1939 were gradually distributed, production was stepped up, the use of substitutes and so-called Volksheilmittel encouraged, and the supply of medicines to the civilian population somewhat curtailed. In the latest phase of the war, however, bomb damage to drug manufacturing plants and a lack of certain raw materials have made themselves increasingly felt. A few preparations, such as insulin, liver extract, alcohol, ether, and typhus vaccine have become scarce, and many other drugs are available only in limited amounts. To meet this situation

insulin was rationed by the introduction of the coupon system (Insulinbezugskarte), the purchase of drugs was made contingent upon presentation of a medical prescription, and the production of new patent medicines (Arzneifertigwaren) was prohibited. However, the supply of vaccines, sera, vitamins, and the most essential drugs, such as sulphonamides, anti-syphilitic preparations, and anti-malaria synthetics, appears to have been fairly adequate.

With the repair of damaged plants and the importation of a few essential raw materials, the German pharmaceutical industry should be able soon to produce drugs in amounts adequate to meet ordinary demands.

Distribution of drugs is made through (1) pharmacies (Apotheken), (2) drugstores (Drogerien), and (3) Material- und Farbenhandlungen, i.e., stores which often carry a few of the preparations allowed for sale outside of pharmacies.

There are elaborate regulations covering trade in drugs (Verkehr mit Arzneimitteln). Drugs which may be sold are classified in three groups. List A (Verzeichnis A) gives the preparations which, under

certain conditions, may be offered for sale by establishments other than pharmacies. Lists B and C contain those drugs which are allowed to be distributed by pharmacies only (apothekenpflichtige Arzneimittel).

Factual information on individual drugs is contained in the official pharmacopoeia, Deutsches Arzneibuch, 6th edition. In addition, a source book on homoeopathic drugs (Homoeopathisches Arzneibuch) was published in 1934.

Patent medicines without declaration as to composition (Geheimmittel) are excluded from sale except at pharmacies. Trade in drugs which may have a toxic effect (Gifte) is subject to a special permit (Gifterlaubnis). The seller is required to record all sales of toxic substances in a special book (Giftbuch), and the purchaser must posses a certificate (Giftschein) showing that he is entitled to acquire such substances. The trade in narcotic drugs (Betäubungsmittel) is regulated by a special Reich law of 1929 bearing the short title Opiumgesetz, and amended by a host of decrees. According to this law, the import (Einfuhr), export (Ausfuhr), and

transit (Durchfuhr) of narcotic drugs on the official list require a permit (Genehmigung) by a special unit, the Opiumstelle, of the Reich Health Office (Reichsgesundheitsamt). Such drugs can be prescribed by physicians, dentists, and veterinarians only, and the prescriptions must be filled in pharmacies. There is a limit to the amount of opium and its derivatives allowed on an individual prescription. If the limit is exceeded for a valid reason, the prescription must be recorded in a special book, the Morphinbuch. Much more stringent are the rules regarding cocaine. Every single prescription of preparations containing cocaine must be recorded in a Kokainbuch.

All pharmacies, drugstores, and other stores carrying drugs are supervised by the health officer (Amtsarzt) and inspected by him regularly, usually once a year.

DYSENTERY (Ruhr).

Dysentery is reportable throughout the Reich. Official statistics do not give an etiological classification of the reported cases. Bacillary infection accounts for the vast majority of all cases. Amebic dysentery was

rare before the war but might become more important as a result of introduction from infected areas.

Reported cases numbered 2425 in 1930; 3430 in 1935; 24,458 in 1940; 10,330 in 1941; and 15,137 in 1942. However, there is reason to assume that the reported cases constitute only a fraction of all. The case rate per 100,000 population increased from 3.8 and 5.1 in 1930 and 1935, respectively, to 27 in 1940, 11 in 1941, and 17 in 1942. Areas with relatively high incidence of dysentery in recent years included Mecklenburg, Wartheland, Bremen, Baden, and Hamburg. The heavy increase in frequency of dysentery during the war parallels a similar development during the First World War.

Unsanitary conditions, in particular the breakdown of sewage disposal and the deterioration of water supply, a shortage of hospital facilities, and the return of dysentery carriers from military service or labor camps may result in a continued high morbidity in general and in changes in the previous regional distribution of dysentery.

Deaths from dysentery totalled 134 in 1930; 131 in 1935; 1497 in 1940; 672 in 1941; and 1872 in 1942. The death rates per 100,000 population were

0.2 in 1930 and 1935, but rose to approximately 1.7, 0.7, and 2.1 in 1940, 1941, and 1942 respectively.

The case fatality, approximately 6 percent before the war, has risen markedly since 1940. It was 12.4 percent in 1942.

The control of dysentery is based on the general principles discussed under COMMUNICABLE DISEASE CONTROL. Specific measures include: (1) exclusion of sick persons, suspected cases, and carriers from the milk trade; (2) prohibition on the employment of carriers in the food industry and trade; (3) compulsory pre-employment examination of kitchen personnel in camps and homes; and (4) regulations concerning the prevention of dysentery in schools. Teachers and pupils who are sick, carriers, or living in families where there is a case of dysentery are forbidden to enter the school building. Readmission after sickness is allowed after three negative bacteriological stool tests taken at 8-day intervals.

EMERGENCY HOSPITAL (Notkrankenhaus).

Emergency hospitals are standardized facilities for the care of the sick, consisting of inter-connected one-story buildings. They were built after the beginning of the systematic air war and are located outside cities, principally in the western and north-western parts of the country. The average emergency hospital has a capacity of about 500 beds. Early in 1944, some 15,000 beds were reported to be available in such facilities.

ENCEPHALITIS, EPIDEMIC or LETHARGIC (Übertragbare Gehirnentzündung).

Epidemic encephalitis is notifiable throughout the Reich. Reported cases numbered 786 in 1940 and 658 in 1941, and the deaths totaled 295 and 294 in these years. The case fatality amounted to more than one-third of all cases in 1940, and nearly one-half in 1941.

According to the information available, the situation has not changed materially during the later years of the war.

FAMILY ALLOWANCES (Kinderbeihilfen).

In line with its population policy, the Nazi regime in 1935 introduced grants-in-aid to large families, i.e., families with four or more children under 16 years of age. The prerequisites were a "certain degree of need" (gewisser Grad von Bedürftigkeit), and a certificate of the health department (Gesundheitsamt) declaring the children to be free of hereditary mental and physical disorders (frei von vererblichen geistigen oder körperlichen Gebrechen). In 1938, this policy was expanded. Families with three or more children were made eligible, and the privilege was extended to all families whose annual income did not exceed 8,000 RM. In 1941, the principle of income limit was given up entirely.

In addition to grants-in-aid from public agencies, financial aid to large families was provided by the Nazi party, and a number of communities adopted a system of "godfathership" (Ehrenpatenschaften) to hereditarily healthy families willing to produce additional children. (See also RACIAL HYGIENE.)

FIRST-AID SERVICE (Rettungswesen).

The general principles of organization of first-

aid and ambulance service are laid down in official rules: Grundsätze für den planmässigen Aufbau und die Ordnung des Rettungs- und Krankenbeförderungswesens. These rules have been followed generally.

At present first-aid service for the general public in cities is made available through facilities in hospitals and special stations (Rettungsstellen or Rettungswachen) located in strategic places, while small communities ordinarily utilize the services of police and fire stations. Most industrial corporations have emergency rooms for their employees. In addition, special associations are responsible for provision of first-aid service in areas with specific dangers: the Deutsche Lebensrettungsgesellschaft serving along the seacoast, the Rettungsdienst serving on inland waterways and the large lakes, and the Alpenverein and the Bergwacht serving in the Alps (Alpen).

It is common practice to inform the public on the location of the nearest first-aid station by notices (Schilder) posted on bill-boards (Anschlagstädulen), and in apartment house entrances, institutions, restaurants, etc.

In the years immediately preceding the war, the existing first-aid system was systematically strengthened and closely coordinated with the air-raid protection system (Luftschutz). In 1943, the Red Cross (Rotes Kreuz), which has long occupied a dominant position in the field through its large number of trained volunteers (frei-willige Sanitätskolonnen), was charged with sole responsibility for the organization of first-aid and ambulance service for civilians. (See also AMBULANCE SERVICE and RED CROSS.)

FOOD CONTROL (Lebensmittelkontrolle).

The number of laws, decrees, and administrative rules relative to the hygienic control of food is so large that even the listing of their titles and dates would require many pages. What complicates the situation further is the disparity in procedure in various parts of the country -- which is in striking contrast with the uniformity emphasized in most fields of health activity. During the war years there has been a relaxation of standards and administrative practices, with detrimental effects on health.

The four most important nation-wide laws pertaining

to protection against danger from unsafe or adulterated food are: (1) the Reich food law (Gesetz über den Verkehr mit Lebensmitteln und Bedarfsgegenständen: short title, Lebensmittelgesetz) adopted in 1927 and recodified on 17 January 1936; (2) the Reich law concerning the inspection of beasts to be slaughtered and of meat (Gesetz betreffend die Schlachtvieh- und Fleischbeschau) adopted in 1900, with amendments and supplementary decrees; (3) the Reich milk law of 31 July 1930 (Reichsmilchgesetz), with amendments and some 30 supplementary decrees; and (4) the law concerning the unification of health administration (Gesetz über die Vereinheitlichung des Gesundheitswesens) of 3 July 1934, with subsequent decrees.

The Reich food law and the decrees for its execution contain precise regulations on hygienic standards for various foods. Lately, legislation has been extended to such items as honey (Honig), coffee (Kaffee), fruit products (Obsterzeugnisse), cocoa (Kakao), ice cream (Speiseeis), mineral water (Tafelwasser), chopped meat (Hackfleisch), duck eggs (Enteneier), and sausages (Wurstwaren).

The Reich law on the inspection of beasts and meat requires the examination of beasts to be slaughtered (Untersuchungspflicht der Schlachttiere), the establishment of inspection districts (Beschaubezirke), official approval of slaughtering (Genehmigung der Schlachtung), and certification that the meat is fit for human consumption (Tauglichkeitserklärung des Fleisches). Public abattoirs in communities with more than 5,000 population must utilize the services of licensed veterinarians. Examination for trichinae (Trichinenschau) is a routine procedure for which special personnel (Trichinenschauer) is employed. It is applied to meat for home consumption (Hausschlachtung) as well as to meat offered for sale.

The Reich milk law applies to cow milk and its products in so far as they are intended for human consumption. Milk from cows with any condition unfavorably affecting the milk is excluded from the milk trade. The various conditions in question are listed in the decree of 15 May 1931. Milk must be treated ^{be} (Behandlungszwang), and it must/properly handled from source of production to consumer. According to the law, treatment may mean cleaning (Reinigungsverfahren) by procedures such as filtration; heating (Erhitzung),

including boiling (Abkochen) or pasteurization (Pasteurisierung); and refrigeration (Tiefkühlung). There is no general requirement of pasteurization, and only a small percentage of the milk is pasteurized. The population is accustomed to boil milk after purchase. The milk (Milch), premises, milk wagons (Milchwagen), milk containers (Kannen), and bottles (Flaschen) must meet minimum standards. The law does not contain very strict regulations as to the condition of stables (Ställe) which leaves much to be desired, in particular in the many areas where small stables (Kleinstellungen) are common.

Legally three grades of milk are distinguished:
(1) Vollmilch, milk meeting minimum standards, in particular as to fat and water content and bacterial count (Keimgehalt); (2) Markenmilch, a higher grade milk produced in establishments meeting stricter standards, including application of the official measures for the eradication of tuberculosis (Tuberkulosetilgungsverfahren); and (3) Vorzugsmilch, the highest grade of milk meeting particularly high standards (besonders hoch bemessene Anforderungen). Persons with any condition that may result in the

transmission of infection are excluded from those occupations in the production and distribution of milk which involve contact with the product. The conditions listed in the law are (1) cases of typhoid, paratyphoid, dysentery, or infectious tuberculosis, (2) suspected cases and carriers of typhoid, paratyphoid, or dysentery; and (3) persons afflicted with ulcera (Geschwüre), purulent wounds (eiternde Wunden), or exanthema (Ausschläge). It must be noted that periodic health examination of milk producers or milk handlers is not obligatory. To prevent unreliable persons from entering the milk trade, a permit is required for engaging in distribution (Abgabe von Milch).

The administrative organization of the hygienic control of food follows a fairly uniform pattern, although there are differences in detail. The police authorities are authorized by law to inspect premises, take specimens, and enforce the existing statutes. A special branch of the police, the Lebensmittelpolizei, is in charge of this field. It employs the services of specially trained inspectors and of professional personnel (beauftragte Sachverständige) including food

chemists (Lebensmittelchemiker or Nahrungsmittelchemiker), veterinarians (Tierärzte), and physicians, usually the health officers (Amtsärzte). For diagnostic purposes a large number of laboratories are available (see LABORATORY, PUBLIC HEALTH). The health officer is responsible for general supervision of the food trade from the point of view of public health, and has police powers.

FOOD POISONING, BACTERIAL (Bakterielle Lebensmittelvergiftung).

Bacterial food poisoning is reportable throughout the Reich. Because of the diagnostic difficulties involved, official figures on the frequency of this disease must be regarded as understatements.

Reported cases of bacterial food poisoning numbered 1,446 in 1930, 1,607 in 1935, 3,158 in 1940, 2,255 in 1941, and 1,940 in 1942. The change in the reporting area must be taken into account in appraising these figures.

A special study of meat poisoning (Fleischvergiftung), based on reports from veterinarians in official positions, gave the number of such cases as 1,357 in 1942. The vast majority of the poisonings

were caused by consumption of sausage (Wurst), beef (Rindfleisch), and pork (Schweinefleisch) in that order, and most of them occurred during the summer months. Revealing is the statement that many cases of meat poisoning could be traced to meat from diseased animals (Notschlachtungsfleisch).

The number of deaths from food poisoning was 49 in 1930, 39 in 1935, 121 in 1940, 84 in 1941, and 83 in 1942.

With the growing shortage of safe food and the decreasing strictness of food control, the frequency and severity of cases of food poisoning have probably increased. (See also FOOD CONTROL and TRICHINOSIS.)

FOREIGN LABOR (*ausländische Arbeiter*).

The very large number of foreign workers imported by the Nazi regime presents a serious health problem. Many of the foreign workers were not in good health on arrival in Germany. All have been living under primitive hygienic conditions, working long hours, and receiving only the most superficial medical care, and that only in grave emergencies. A large amount of neglected illness

must be anticipated in this group. In particular, tuberculosis, venereal diseases, parasitic and infectious skin diseases as well as lice infestation, malnutrition, and vitamin deficiency diseases are said to be rampant.

Camps for foreign workers accomodate from 10 to 3,000 persons. A few have brick buildings with spacious rooms and showers. The large majority consist of most primitive barracks. Each camp is supposed to have 2.8 sick beds for every 100 workers. That this rule has been applied generally is open to doubt. In some instances medical service is provided by foreign physicians working under the supervision of the German authorities. In many instances, there is nothing resembling competent medical care, as medical attendants do most of the work. In still other instances the sick must walk miles to receive medical attention.

Unless the release and repatriation of foreign labor are made subject to a health examination, a wide spread of infectious diseases is more than probable.

GARBAGE AND REFUSE DISPOSAL (Abfallbeseitigung).

Household waste in Germany usually consists of (1) sweepings (Staub) and a considerable amount of ashes (Asche) from the widely used stoves (Öfen) burning wood (Holz) and coal (Kohle); (2) kitchen waste (Küchenabfälle); and (3) rubbish.

As a general rule, the property owner is responsible for making arrangements for the collection of all types of refuse at the source. In many communities, the contents of small rubbish cans (Mülleimer) and garbage pails (Abfalleimer) which are standard household equipment are emptied into large receptacles (Müllküsten) in the backyard. In other communities, the containers are placed at the curb of the street every morning. The use of separate containers for ashes and kitchen wastes prevails. Under primitive conditions, household waste is dumped into pits (Gruben) behind the houses.

The collection and disposal of household garbage and refuse -- the so-called Müllabfuhr -- are organized under public auspices in the majority of all communities. Individual families are compelled to utilize the public system. The community maintains

garbage trucks (Müllwagen) regularly routed to all districts to empty the receptacles, which are lined up at the curb or placed in the backyards. In some instances the authorities have contracts with business firms for the collection and disposal of all types of refuse.

The methods of disposal include dumping (Anschüttung), not infrequently on so-called Müllablaendeplätze; use as animal food (Verfütterung) and for the fertilization of crops (Düngung); burial (Vergraben); and -- occasionally -- incineration (Verbrennung).

The war has brought the collection system more or less to a standstill. In many cities garbage and refuse pile up in backyards, on streets, and on public squares, and in other communities it is thrown into canals and rivers. As a result of the breakdown of the collection system rats and flies have been thriving.

To remove street refuse (Strassenkehricht), more advanced cities have long used the method of flushing streets by special vehicles, called Spritzmaschinen, or of sweeping the streets with so-called Kehrmaschinen.

In many communities streets are swept by crews equipped with brooms, and the refuse, piled up at the curb, is collected by push-cart (Karre) or other vehicle (Abfuhrwagen). In general the community has assumed responsibility for this type of sanitation. It goes without saying that such activities have practically ceased in recent years.

The health officer (Amtsarzt) is responsible for the maintenance of hygienic standards in collecting and disposing of garbage and refuse. Administrative responsibility for this activity is vested in a special division of the city or county government.

HEALTH DEPARTMENT (Gesundheitsamt).

Official health departments (Gesundheitsämter) exist in practically every rural county (Landkreis) and urban county (Stadtkreis) as defined by law. Occasionally one department serves several counties. In such a case a sufficient number of auxiliary offices (Nebenstellen) must be maintained in various sections of the area covered. Cities of more than 400,000 population are authorized to establish branch offices (Bezirksstellen) in addition to the central office (Hauptstelle), and many have done so. There are marked differences between the existing agencies in regard to type of control, staffing, functions, powers, and method of financial support.

Health departments are state institutions, according to a paragraph in the basic law on the unification of health administration of 3 July 1934 (Gesetz über die Vereinheitlichung des Gesundheitswesens), the states being departments of the Reich for purposes of general administration. This means only that the state has assumed responsibility for such agencies, not that all health departments are actually supported and administered by the state.

Before the adoption of the law of 1934 by the Nazi regime, two types of official health agency had been in existence: (1) the office of the district health officer, established and maintained by the state to supervise all health activities, non-governmental as well as governmental; (2) the communal health department (Kommunales Gesundheitsamt), set up and operated by units of local government -- primarily by cities, the Stadtgesundheitsamt, and less frequently by counties, the Kreisgesundheitsamt -- to administer their own tax-supported health services.

The unification law was heralded as a measure to eliminate this dualism. Additional motives were the creation of centralized machinery on which the regime could rely, and the curbing of everything resembling self-government. Some of the long-established and well organized communal health departments have been taken over by the state. Others have remained under direct control of the locality, but have been "recognized" as qualified to perform certain functions delegated by the state (Auftragsangelegenheiten). On the whole, the vast majority of health departments are state-controlled.

The total number of health departments operating in 1937 was 748, of which only 39 were headed by a local government officer. Early in 1943 there were said to be about 1,100 health departments in Germany and the annexed and occupied areas.

All departments are headed by physicians, the health officers (Amtsärzte), and staffed with a varying number of professional and clerical personnel. This staff comprises (1) medical personnel; (2) non-medical health personnel (Ärztliches Hilfspersonal), including public health nurses (Gesundheitsfürsorgerinnen), laboratory assistants (technische Assistentinnen), health inspectors (Gesundheitsaufseher), and disinfectors (Desinfektoren); and (3) clerical personnel (Bürokräfte). The number and types of personnel employed depend on the extent to which the local health department is responsible for direct service, in addition to the supervisory functions required by the state. All medical and non-medical health personnel are supervised by the health officer (Amtsarzt). (For details on personnel see the respective headings.)

The functions of the health department are defined by the law of 1934. Essentially, they include

fact finding, analysis, advice from the medical point of view (ärztliche Feststellung und Begutachtung) on "how to meet health problems and improve the public health", and supervision of the application of public health statutes. The health department is responsible for:

- A. Execution of medical tasks in regard to
 1. health police (Gesundheitspolizei), i.e., law enforcement in all fields of health service
 2. racial hygiene (Erb- und Rassenpflege)
 3. health education (gesundheitliche Volksbelehrung)
 4. school health service (Schulgesundheitspflege)
 5. maternal and child health service (Mütter- und Kinderberatung)
 6. campaigns against tuberculosis (Fürsorge für Tuberkulose), venereal diseases (Fürsorge für Geschlechtskrankheit), physical handicaps (Krüppelfürsorge), chronic disabling illnesses (Siechenfürsorge), and alcoholism and drug addiction (Fürsorge für Süchtige)
- B. Participation in the promotion of physical education (Förderung der Leibesübungen)
- C. Performance of such state health officer activities (amtsärztliche Tätigkeit), forensic activities

(gerichtsärztliche Tätigkeit), and supervisory activities, including certification, (vertrauensärztliche Tätigkeit) as are delegated by law.

The average health department does not administer hospitals, sanatoria, convalescent homes, and similar institutions, but is charged with their supervision. However, agencies maintained by cities and counties often have responsibility for administration of the publicly owned medical-care facilities.

In communicable disease and food control, the health department has power to take direct action as deemed necessary, and to issue temporary injunctions. In all other matters pertaining to health, the health department advises on the measures to be taken, but leaves their execution to the various agencies concerned -- school authorities, police and others.

The costs of the health departments are met from (1) tax funds, including appropriations from the Reich, states (or Gaue), and local units of government; and (2) income from charges for services rendered -- for instance, performing autopsies, making tests or issuing certificates. Fees are fixed by a schedule (Gebührentarif).

The files (Akten) kept by all health departments

cover the following subjects: (A) general organization (Organisation); (B) general operation and relationship to other authorities, health personnel, and the public (Dienstordnung, Dienstverkehr); (C) personnel in the employ of the health department (Beamte, Angestellte und Arbeiter); (D) physicians and dentists in private practice (Ärzte und Zahnärzte); (E) pharmacies (Apotheken); (F) the drug trade exclusive of pharmacies (Drogenhandel); (G) midwives (Hebammen); (H and I) other auxiliary health personnel (sonstiges ärztliches Hilfspersonal); (L and M) health police (Gesundheitspolizei); and (N to Z) racial hygiene (Erb- und Rassenpflege).

The files are classified by letter, roman numeral and subject matter, according to a national key. To give an example, the files listing the physicians and dentists in practice are marked D, IV, 1, Verzeichnis der Ärzte und Zahnärzte.

If proper action is taken in time, these records will be available to Allied authorities, although they are certain to be incomplete in some respects.

HEALTH EDUCATION (Gesundheitliche Volksbelehrung).

Prior to 1933, health education in Germany was carried out along the same lines as in other countries.

Preventive clinics and the school health service emphasized the education and guidance of the individual in personal hygiene, community health organization, and proper utilization of available health services. Cities and counties, social insurance organizations, and numerous voluntary associations promoted mass education in hygiene by the spoken and printed word, exhibits, plays, etc. The Deutsche Hygiene Museum in Dresden established an enviable record of successful activity in this field.

The Nazi regime did its utmost to distort the objectives of health education by concentrating on indoctrination in "race and blood". The health department was charged with responsibility for "coordinating" the educational activities of all public and non-governmental health organizations, and for keeping them in line. At the national level, a Reich Advisory Council on Public Health (Reichsausschuss für Volksgesundheitsdienst) was established, ostensibly for the purpose of coordinating the work of the many voluntary health agencies. Actually the council devoted most of its energy to propaganda for the Nazi version of health education.

HEALTH OFFICER (Amtsarzt).

The term health officer denotes a physician who is a civil servant either of the state (Staatsbeamter) or of the locality (Gemeindebeamter). It must be borne in mind that the National-Socialist regime deprived the political units called "states" of their independence, and made them administrative divisions of the Reich. The health officers, with the exception of those attached to higher authorities (see below), belong to the personnel of the health department (Personal des Gesundheitsamtes).

According to their functions health officers may be classified in two broad categories: (1) physicians serving primarily as administrators (Amtsärzte) and (2) physicians appointed primarily to render direct service in the health department, preventive clinics, or other institutions such as schools. This distinction is the rule in districts with 50,000 or more inhabitants. In smaller districts the health officer may perform both functions. At large ports, such as Hamburg and Bremen, there is a special type of health officer (Hafenarzt) employed for specific duties connected with port activities.

The Amtsarzt is the head of the health department

(Leiter des Gesundheitsamtes). He is a full-time, salaried physician. In districts with more than 50,000 population, he is assisted by a full-time, salaried deputy health officer (ständiger Vertreter des Amtsarztes). The Amtsarzt appointed by the state is supervised by a higher authority -- in Prussia the Regierungspräsident -- to whose office a full-time, salaried medical officer is attached. The executive health officer in the service of a city or county is responsible to the head of the political unit (Leiter des Kreises, i.e., Bürgermeister and Landrat, respectively) but in so far as he performs state functions is subject to supervision by the same authority as the state health officer. Detailed rules regulate the functional integration of the activities of both types of health officers.

To become a medical administrator with the powers of Amtsarzt, the candidate must (1) be a duly appointed (bestallter) physician holding the degree of doctor of medicine, (2) have successfully completed a special training and examination (staatsärztliche Prüfung), and (3) have been in medical practice for a period of five years after "appointment" (Bestallung) as physician. To prepare physicians with proper qualifications for responsible positions, assistant health officers with the title

"Medizinalassessor" are assigned to the health department maintained by the state.

The functions (Aufgabenkreis) of the Amtsarzt are so numerous that twenty-two chapters of an official publication called Dienstordnung are needed to describe them. In broad terms, the Amtsarzt is consultant to the administration on all matters pertaining to health, supervises health conditions and health activities -- non-governmental as well as governmental -- in his district, and enforces statutes dealing with or related to public health. Some of the major functions include (1) medical participation in the control of communicable diseases, eugenic measures, and sanitation of the environment; (2) supervision of all professional and auxiliary health personnel in private practice, of non-medical practitioners (Heilpraktiker), of all hospitals and related institutions -- including those operated for profit as well as the non-profit, voluntary and public facilities -- and of the pharmacies; and (3) examination of individuals, and certification where required by statute or administrative rules.

The heads of the municipal health departments are primarily responsible for administration of the tax-supported services maintained by the communities.

In addition, they carry out certain of the state health officer functions delegated to the department.

The physicians and dentists employed to render direct service are appointed according to competence, i.e., specialists, if available, for child health service, crippled children's programs, venereal disease clinics, tuberculosis clinics, etc. They are not required to take the training and examination prescribed for the Amtsarzt but are urged to attend special courses. Most of them are appointed on a part-time basis, either as "beamtete Ärzte" or "Hilfsärzte". Early in 1943 about 2,600 full-time and 10,000 part-time physicians were said to be affiliated with health departments.

HEALTH PERSONNEL (Berufsmässig tätige Heil- und Pflegepersonen).

Following is a summary of health personnel available for direct service to the civilian population early in 1939. Details are discussed under the individual headings of the text.

	<u>Number</u>	<u>Ratio to population</u>
Physicians	47,725	1:1,432
Dentists	15,006	1:4,545
Pharmacists	12,432	1:5,555
Pharmaceutical assistants and apprentices	3,858	1:16,666
Midwives	23,745	1:2,857
Dental technicians	20,885	1:3,330
Medical attendants	12,431	1:5,555
General nurses	135,450	1:508
Childrens' nurses	11,002	1:6,230
Child-bed attendants	1,483	1:46,000
Disinfectors	5,816	1:11,800
Non-medical practitioners	10,067	1:6,666

HELMINTHIASIS (Verwurmung).

Infestation with intestinal parasites is frequent in Germany. Enterobius vermicularis (Fadenwurm) and Ascaria lumbricoides (Spulwurm) are common, and Taenia saginata and Taenia solium (Bandwurm) are frequent. Echinococcus (Echinokokken) and Ancylostoma (Wurmkrankheit des Bergleute) are encountered occasionally, the latter primarily in mining districts.

HOSPITAL (Krankenhaus). .

The German hospital system is predominantly public. The larger cities, the counties, and large units especially created for the administration of public welfare, the so-called Landesfürsorgeverbände, all maintain and administer hospitals of their own. The first two groups have assumed responsibility mainly for general hospitals (allgemeine städtische Krankenhäuser and Kreiskrankenhäuser). The last group is legally charged with providing and administering special facilities for the mentally sick and defective, epileptics, deaf-mutes, the blind, and the physically handicapped. The states or equivalent units support and control the teaching hospitals (Universitätskliniken) affiliated with state universities.

Social insurance organizations (Sozialversicherungsträger) operate and administer a considerable number of facilities for medical care. The industrial accident insurance system (Unfallversicherung) and the miners' insurance system (Knappschaftsversicherung) possess general as well as special hospitals, while the pension insurance system (Invalidenversicherung and Angestellten-

versicherung) owns primarily special facilities such as tuberculosis sanatoria, preventoria, convalescent homes, and various types of institutions in spas and resort places.

Non-profit voluntary hospitals are supported either by church organizations or non-sectarian groups. Catholic hospitals (katholische Krankenhäuser) and facilities maintained by the protestant church, including the Diakonissenkrankenhäuser, are of considerable importance in some parts of Germany. Jewish hospitals have been taken over by the Nazi regime.

Proprietary hospitals (private Anstalten, often called Privatkliniken) are operated for profit by physicians, nurses, or other individuals or groups. Most of them are small and specialized for treatment of patients with certain diseases, or for maternity service (Privatentbindungsanstalten).

At the end of 1939, 65 percent of all hospital beds were in public facilities, 29 percent in non-profit voluntary facilities, and 6 percent in proprietary institutions.

The official classification distinguishes 16

types of facilities for medical care, according to the services available. There are: (1) general hospitals (allgemeine Krankenhäuser); (2) tuberculosis hospitals and sanatoria primarily for adults (Tuberkulose-krankenhäuser und Heilstätten); (3) tuberculosis sanatoria and hospitals primarily for children; (4) children's hospitals (Säuglings- und Kinderkrankenhäuser); (5) orthopedic hospitals (Krüppelheilanstalten); (6) eye hospitals (Augenheilanstalten); (7) hospitals for skin and venereal diseases (Heilanstalten für Haut- und Geschlechtskranke); (8) chronic disease hospitals (Krankenpflegeanstalten, Pflegeheime); (9) mental hospitals (Heil- und Pflegeanstalten für Geisteskranke); (10) institutions for persons with mental defects (Schwachsinnigenanstalten); (11) hospitals for patients with neurotic and neurological conditions (Heilanstalten für neurologisch Kranke); (12) institutions for alcoholics and drug addicts (Trinkerheilanstalten); (13) maternity hospitals and homes (Entbindungsanstalten); (14) gynecological hospitals (gynäkologische Anstalten); (15) other special hospitals; and (16) hospital departments in penal institutions (Krankenabteilungen in Gefangenenanstalten).

Before the war, general hospitals led in bed

capacity as well as in number. More than 3,000 general hospitals provided about 353,000 beds, or 54 percent of the total available. The number of general hospital beds per 1,000 population was approximately 4.6. About half of all general hospital beds were in institutions with fewer than 50 beds. Most of the rest were in hospitals with 50 to 150 beds. Mental hospitals ranked second in total number and in the number of beds. (For details see MENTAL HOSPITALS.)

At the end of 1939, Germany had a total of 4,861 hospitals for civilians with a capacity of 663,000 beds, or a rate of nearly 9 beds per 1,000 population. These figures include the territory of the Old Reich, Memelland, and the Reichsgau Ostmark. Relatively best supplied were Hamburg, Westphalia, Rhineprovince, Baden and Hessen-Nassau -- all of which had bed rates exceeding 10 per 1,000. The relatively lowest bed rates -- in the neighborhood of 6 per 1,000 -- were found in Thuringia, Pomerania, and East Prussia.

During the war there has developed a marked shortage of hospital facilities. To ease the rather serious situation and avoid losses by air raids, a substantial number of new hospitals have been built

outside large communities. (See EMERGENCY HOSPITALS.) It is not known how large a bed capacity is available at present. Acute shortages may be expected in most of the cities. However, many institutions located at a distance from urban centers and formerly used as convalescent homes might be easily converted into emergency hospitals. (See CONVALESCENT HOME.)

The establishment of tax-supported and non-profit voluntary hospitals is subject to approval (Genehmigung) by the local authority. The building of proprietary hospitals requires a license (Konzession) by the higher authority. The plans must meet minimum requirements laid down in fairly uniform police ordinances. Prussian regulations concerning the building and equipment of hospitals (Vorschriften über Anlage, Bau und Einrichtung von Kranken-, Heil- und Pflegeanstalten) afford a typical example of the policy followed in general.

The majority of the hospitals have closed staffs. In 1939, only some 10,000 physicians, mainly accredited specialists, had the privilege of treating their own patients in hospitals, and this system was most common in voluntary hospitals. The physicians who belong to a closed staff serve on a full-time basis, (14,000 physicians in 1939) or on a part-time basis (27,000

physicians in 1939). In general, the staff is headed by a medical director (leitender Arzt or Chefarzt), and comprises a varying number of division chiefs (dirigierende Ärzte), senior residents (Oberärzte), junior residents (Assistenzärzte), and volunteers (Voluntärärzte).

All hospitals except proprietary institutions admit everybody, regardless of economic status. They are required by law to accept any emergency case. The sickness insurance, accident insurance, and pension insurance systems, as well as the welfare agencies are authorized by law to provide for necessary hospital care. Hospitalization without consent of the patient is possible under the laws concerning communicable disease and venereal disease control, if isolation of the patient is necessary. Furthermore, sickness insurance organizations may order hospitalization if home care is inadequate, the condition of the patient is infectious, or the behavior of the sick precludes successful treatment outside an institution.

The greater part of the income of all general and certain special hospitals comes from payments made by sickness and accident insurance organizations. These paid for approximately two-thirds of the total patient

days before the war. The rest is made up from payments by voluntary insurance organizations, public agencies, and private patients.

The operation of all hospitals is strictly supervised. The health officer (Amtsarzt) is obliged to inspect, once a year, each public, non-profit voluntary, and proprietary hospital located in his district, the only exception being the state-controlled hospitals which are supervised by the higher authority. During the war this requirement has been relaxed. Any shortcomings discovered by the Amtsarzt on the occasion of his regular visit or otherwise must be remedied. The Amtsarzt has power to enforce compliance with his orders, and if necessary can recommend drastic measures, including cancellation of the license.

Three national organizations represent the various groups active in the hospital field: (1) the Deutscher Gemeindetag which maintains an advisory council, the Gutachterausschuss für das Öffentliche Krankenhauswesen, speaks for the public hospitals; (2) the Reichsverband der gemeinützigen Krankenpflegeanstalten Deutschlands represents the non-profit voluntary hospitals; and (3) the Reichsverband Deutscher Privatkrankenanstalten represents the proprietary hospitals.

ILLEGITIMACY (Unehelichkeit).

The percentage of illegitimate live births (Lebendgeburten) was 10.2 in 1913, 12 in 1930, and 7.8 in 1935. Of 100 still births (Totgeburten), 13.2 were illegitimate in 1913, 16.4 in 1930, and 11 in 1935.

In normal times the frequency of illegitimate births was relatively highest in communities with less than 2,000 inhabitants and relatively lowest in cities with more than 100,000 population. The peak of the curve fell in the age groups of 21 and 22.

The population policy of the Nazi regime has probably resulted in an increase in the number of children born out of wedlock. The large proportion of this group in the population presents a considerable health problem. Experience has shown that morbidity and mortality are comparatively high among illegitimate children.

The Reich law concerning child welfare (Reichsgesetz für Jugendwohlfahrt), adopted by the Weimar Republic in 1922, contains detailed provisions designed to improve the conditions of illegitimate children. The child welfare department (Jugendamt) is charged with responsibility for the execution of these provisions,

and the health department (Gesundheitsamt) is responsible for matters pertaining to health.

INDUSTRIAL HYGIENE (Gewerbehygiene).

Countless laws, decrees, and police ordinances directly or indirectly refer to industrial hygiene. Seven statutes are of particular importance. (1) The Reich trade code (Reichsgewerbeordnung) and the decrees for its execution set forth the minimum safety and hygiene requirements to be met by industrial and related establishments (Gewerbetriebe). (2) The decree concerning hours of work (Verordnung über die Arbeitszeit) fixes a maximum for each of the various types of industry, for women, and for minors. Particular emphasis is placed on the protection of children and women against nightwork, overtime work, and employment in hazardous industries. (3) The law concerning home industry (Gesetz über die Heimarbeit) contains provisions designed to prevent unsanitary conditions in this type of work. (4) The law concerning child labor (Gesetz über die Kinderarbeit) regulates the employment of minors. (5) The law concerning the protection of working mothers (Gesetz zum Schutze der erwerbstätigen Mutter) provides for the protection of women prior to and after delivery. (6) The Reich insurance code (Reichsversicherungsordnung) requires the special bodies administering accident insurance the Berufsgenossenschaften, to provide for accident prevention (Unfall-

verhütung), not only in industrial plants, but also in all other establishments (Betriebe) which are subject to compulsory accident insurance (Unfallversicherung).

(7) The law concerning the unification of health administration (Gesetz über die Vereinheitlichung des Gesundheitswesens) defines the functions and powers of the health officer (Amtsarzt) in regard to industrial hygiene.

The administrative organization of industrial hygiene is as complex as the legislation on the subject. At the local and intermediate level of government, administrative responsibility for the enforcement of industrial hygiene measures is divided among: (1) technical officers, the Gewerbeaufsichtsbeamten or, in the mining industry, Bergrevierbeamten who represent the so-called Gewerbeaufsicht; (2) the health officers (Amtsärzte); and (3) the police. The executive officers of the Gewerbeaufsicht have the title Gewerberat, or in the mining industry, Bergrat.

Each higher administrative agency has one full-time physician with special experience in industrial hygiene, the staatlicher Gewerbearzt. In Prussia, these officials are attached to the office of the Regierungspräsident, and in most of the other sections of the country to the

state agency. A list of all staatliche Gewerbeärzte with the location of their offices and their administrative districts is published in the Reichsgesundheitsblatt 1939, p. 487.

The health officer participates in the licensing of specified plants by advising on hygienic questions, inspects the sanitary conditions in factories, and advises the police on measures designed to ensure compliance of the factory management with statutes concerning sanitation, accident prevention, prevention of occupational diseases, and related problems.

At the national level, responsibility for industrial hygiene is vested in the Reich Ministry of Labor (Reichsarbeitsministerium), while the work of the health officers is directed by the Reich Ministry of the Interior (Reichsministerium des Innern).

A pre-employment medical examination is mandatory for all job applicants in certain industries specified by law or decree, and for youth in other designated industries. Periodic health examinations are required in a number of hazardous employments, such as work with lead, chromates, zinc, rubber, etc.

For decades, large industrial corporations have

employed part-time or full-time industrial physicians (Betriebsärzte), whose functions include supervision of the plant and the workers from the hygienic point of view, as well as treatment of the sick. The Nazi regime, for obvious reasons, has made every effort to increase the number of industrial physicians, primarily in war industries. The German Labor Front (Deutsche Arbeitsfront) has been particularly active in this development. In 1943, about 270 full-time and more than 4,000 part-time industrial physicians served some 5,800 factories. Furthermore, a large number of industrial corporations employ safety engineers (Sicherheitsingenieure).

INFANT HEALTH SERVICE (Säuglingsfürsorge).

The objectives of infant health service in Germany are (1) education of parents in the proper rearing of the infant (Erziehung zu richtiger Aufzucht); (2) the organization of suitable environmental conditions (Ordnung der Umweltverhältnisse); and (3) control of communicable diseases in infancy (Bekämpfung der Übertragbaren Krankheiten des Säuglingsalters).

The most important statutes pertaining to this type of preventive health service are (1) the Reich law of 17 May 1942 concerning the protection of working

mothers (Gesetz zum Schutze der erwerbstätigen Mutter); (2) the Reich law of 9 July 1922 concerning child welfare (Reichsgesetz für Jugendwohlfahrt); (3) the Reich decree of 13 February 1924 concerning public welfare (Reichs Verordnung über die Fürsorgepflicht); (4) the Reich Insurance Code (Reichsversicherungsordnung); and (5) the Reich law of 3 July 1934 concerning the unification of health administration (Gesetz über die Vereinheitlichung des Gesundheitswesens).

The cornerstone of infant health service is the infant health clinic (Säuglingsfürsorgestelle, also called Mütterberatungsstelle). This type of facility exists by law in every health department district, and the health department must see to it that the number and distribution of these facilities are adequate. In most of the communities, infant health clinics are combined with prenatal clinics (Schwangerenfürsorgestellen); in a number of communities, they also include preschool child health clinics (Kleinkinderfürsorgestellen or Kleinkinderberatungstellen). As far as can be judged from the published reports, the majority of the infant health clinics are public institutions affiliated with the health departments (Dienststellen der Gesundheits-

Ämter), and most of the others are maintained by organizations of the N.S. party. Infant health clinics that are not merely branch offices are headed by physicians, most of whom serve on a part-time basis, and staffed with full-time nurses. The infant health clinics receive reports on all births from the registrars (Standesämter) and, on the basis of these lists, organize the supervision of all infants in need of protection.

Before the war, it was not uncommon to find in large cities infant health clinics extending their services to nine-tenths of all newborn children. In rural areas, they usually reached little more than one-third of the young babies.

The proportion of children regularly seen by the clinics tends to decline rapidly after the third month of life. All foster children (Pflegekinder), however, remain under constant supervision.

The main functions of the infant health clinic are (1) medical examination and supervision of infants; (2) health guidance of parents by physicians and specially trained nurse-social workers, the so-called Gesundheitsfürsorgerinnen, who make home visits in addition to assisting at clinics; (3) propaganda for breastfeeding and -- where feasible -- payment of nursing

allowances (Stillgelder) provided by sickness insurance and public welfare; (4) distribution of such items as vitamins; (5) prophylactic treatment, particularly by ultra-violet lamp; (6) smallpox vaccination and immunizations, particularly against diphtheria.

A second type of facility much used for health purposes is the day nursery or crèche (Krippe). Enforcement of minimum standards as to physical plant and operation is a responsibility of the health officer (Amtsarzt).

For the institutional care of well infants there are (1) public and non-governmental homes for mother and child (Mütter- und Säuglingsheime), which are much used to enable unmarried mothers to stay with their children for a limited period of time, and (2) public orphan asylums with divisions for infants who have lost their parents.

Hospital care of sick infants is provided through babies' hospitals (Säuglingsrankenhäuser), children's hospitals (Kinderkrankenhäuser), general hospitals (allgemeine Krankenhäuser), and maternity hospitals (Entbindungsanstalten). The last three are generally equipped with divisions for infants. The majority of these hospitals are maintained by cities and counties.

Some are part of university hospitals controlled by the state. Most of the rest are the property of non-governmental organizations. All but the state-controlled hospital facilities are under the general supervision of the health officer. (See also MATERNAL HEALTH SERVICE and WELFARE.)

INFANT MORTALITY (Sauglingssterblichkeit).

Infant mortality in Germany has declined markedly since the beginning of this century. The number of infant deaths per 1,000 live births (Lebendgeburten) exceeded 200 in 1900, fell to 162 in 1910 and, after the first world war, dropped sharply to 85 in 1930 and 69 in 1935. In 1939, the infant mortality rate was down to 60, the lowest point on record. Beginning with 1940, the situation deteriorated. Available figures, however, are misleading, as they include many annexed territories always distinguished by a relatively higher infant mortality. In 1942, the infant mortality in Greater Germany, including Austria, Sudetenland, Danzig, and Memel, was 70 per 1,000.

In earlier times, a great many infant lives were lost as a result of nutritional disturbances (Ernährungs-

störungen) and acute gastrointestinal diseases (Magen-Darmkrankheiten). Deaths among artificially fed infants were much more frequent than among the breast-fed (gestillt). Reflecting this situation, the curve of the infant mortality showed a high peak during the summer months (Sommergipfel). In recent times, nutritional disorders and diseases of the alimentary tract have been greatly reduced, and consequently the summer peak of infant mortality has more or less disappeared. At present, congenital conditions and birth injuries account for the majority of all infant deaths, and premature birth is the second most frequent cause.

Of special importance is the fact that a considerable number of deaths among infants is due to respiratory infections, in particular influenza (Grippe). Significantly, the curve of infant mortality is now characterized by a winter peak (Wintergipfel). With rapid deterioration of socio-economic conditions in Germany and the curtailment of infant health service, respiratory infections are likely to play a much larger role as cause of death in infancy.

In Germany, as in many countries, infant mortality

is comparatively low in high income groups and high among people at the bottom of the economic scale. In one city, for instance, infant deaths per 1,000 live births numbered 34 in well-to-do families, 66 in middle-class families, and 135 in the unskilled labor group with relatively many illegitimate children. That much of this inequality has persisted is indicated by recent reports from large cities, such as Kiel. Of particular importance is the fact that the frequency of death among illegitimate infants has been for a long time about twice as high as among other infants. It must be borne in mind that the number of illegitimate births was large in the past and has probably increased during the war. (For details see ILLEGITIMACY.)

INFLUENZA (Grippe).

Influenza is not reportable in the Reich. Figures on the incidence of influenza, which are published by such bodies as the administrations of sickness insurance, must be used with great caution, since the designation "influenza" in many cases conceals the lack of a definite diagnosis.

In recent years, epidemics of real influenza have

occurred in various parts of Germany, but they have not assumed dangerous proportions. So far the course of the disease has been mild.

The lowering of the vital resistance of the civilian population after many years of inadequate food and overwork, and the crowding of people in emergency shelters favor widespread outbreaks of influenza after the end of hostilities.

LABORATORY, PUBLIC HEALTH (Untersuchungsamt).

The establishment and maintenance of adequate public health laboratories are public responsibilities in Germany. There are two types of public health laboratory: (1) state-controlled institutions, which are either separate institutions (staatliche Medizinaluntersuchungsämter) or divisions of state universities (staatliche hygienische Institute); and (2) municipal institutions (städtische Untersuchungsämter, städtische bakteriologische Institute), which are approved by the state for performance of the functions of public health laboratories. Both groups emphasize bacteriological and serological work, although in some instances a much larger field is covered. The state institutions are supervised by the higher authority, and the others by the health officer (Amtsarzt).

Public health laboratory service is organized on a regional basis. The institutions are distributed evenly throughout the Reich, each being responsible for a definite area. Costs of the service are defrayed primarily out of tax appropriations, although income from fees plays some role. Fees are uniformly fixed by a fee schedule (Gebührenordnung).

In addition to public facilities, there are proprietary laboratories (private bakteriologische Laboratorien). Their establishment is contingent upon a permit (Erlaubnis), and their operation is closely supervised. The higher authority is charged with making two inspections a year, and the health officer (Amtsarzt) is responsible for general supervision (laufende Überwachung).

All laboratories, public or proprietary, are required to report to the Amtsarzt any positive tests related to notifiable diseases.

Apart from Medizinaluntersuchungsämtern, there exist a considerable number of highly specialized diagnostic and research laboratories supported out of tax funds. Outstanding among them are (1) chemical laboratories (chemische Untersuchungsanstalten) which, among other activities, carry out procedures necessary for the control of the food trade; (2) institutions specializing in food analysis (Nahrungsmitteluntersuchungsämter); and (3) laboratories specializing in the investigation of animal diseases and foods (tierärztlicheuntersuchungsämter or Veterinäruntersuchungsämter). The first two types are maintained primarily by cities or by cities and counties jointly, while the third type is generally supported

by the state. (See also COMMUNICABLE DISEASE CONTROL and FOOD CONTROL.)

LABORATORY TECHNICIAN (Medizinisch-technische Assistentin).

The occupation of laboratory technician is typically a woman's occupation. It can be taken up only by persons possessing a permit (Ausweis).

The law regulating this field of activity distinguishes medizinisch-technische Gehilfinnen from medizinisch-technische Assistentinnen, i.e., a lower and a higher grade of laboratory technician. Persons belonging to the lower group assist physicians in general, and in X-ray work, physical therapy, and clinical-chemical tests in particular. In addition, they make routine microscopical examinations under medical supervision. The second group has wider functions: the Assistentin also assists in radium-therapy, makes tissue examinations, and does bacteriological work. While requirements as to educational background and personal qualifications are identical, the professional training required differs for each group according to the functions to be performed. General requirements include completion of the eighteenth year of life, one year of household work and a nurse's aide

course as well as experience in shorthand and typewriting before admission to the professional school. Professional training must be taken at a state-approved institution (Lehranstalt) affiliated with a hospital and directed by a physician. It lasts two years for future Assistentinnen and one year for future Gehilfinnen. In either case, a state-board examination must be passed before a permit to engage in the profession is issued. The large majority of laboratory technicians are employed in public health laboratories and in hospitals of various types.

Accurate information on the number and distribution of laboratory technicians is lacking. However, it may be assumed that enough trained personnel is available to meet ordinary demands.

LEPROSY (Lepra, Aussatz).

Leprosy is reportable throughout the Reich. This disease has become so rare in Germany that each new case creates a sensation. Between 1930 and 1939 the largest number of cases reported was 6 and the lowest 2 per year. All had acquired the disease in foreign countries.

LICE (Läuse).

In normal times, infestation with body lice, head lice, or both (Verlausung) was not infrequent among persons living in slum districts, but rare among other groups of the population. Pubic lice were frequently observed among promiscuous persons. During the First World War and again beginning with 1940, the lice problem became serious, as a result of the general deterioration of standards of living among the whole population and the influx of persons who had not gone through methodical disinfection.

Lack of cleanliness coupled with the gradual breakdown of the public health machinery has resulted in the reappearance of two formerly extremely rare louse-borne infections: typhus fever (Fleckfieber) and relapsing fever (Rückfallfieber). It is safe to assume that body lice (Kleiderläuse), head lice (Kopfläuse), and pubic lice (Filzläuse) will continue to be frequent for some time to come.

The prevention of large-scale lice infestation will depend largely on the continuation and expansion of well-established practices: (1) disinfection at all frontiers of soldiers and civilians returning to

Germany; (2) systematic inspection and treatment of all children in schools, convalescent homes, and similar institutions, and of all adults attending clinics; and (3) the reestablishment of minimum sanitary and economic conditions. (See also RELAPSING FEVER and TYPHUS FEVER.)

MALARIA (Malaria, popularly called Wechselfieber).

Before the war, the total number of malaria cases was small. There were foci of infection in the north-west, in the area of Emden and Wilhelmshaven, and in the southeast around Pless in Silesia. The prevailing type of malaria is the benign tertian (Plasmodium vivax), and the principal vector is Anopheles labranchiae atroparvus, which breeds in salty or brackish water.

During the war, malaria morbidity has increased as a result of introduction of the disease by soldiers, foreign labor, and prisoners of war from the East and the Mediterranean countries. Reported were 422 cases in 1940, 1,607 cases in 1941, and 711 cases in 1942, or rates of approximately 0.5, 2.0 and 0.8 respectively per 100,000 population. Despite the comparative increase, malaria presents a minor problem. It can be expected to remain a local problem, if proper care is taken of returning malaria carriers.

Deaths from malaria numbered 32 in 1930; 38 in 1935; and 3 each in 1940, 1941, and 1942. (The last figures are questionable).

Control measures are the usual ones. Up to the end of 1942, the supply of quinine (Chinin), atebrine,

and plasmochin seems to have been sufficient.

MARRIAGE LOANS (Ehestandsdarlehen).

In June 1933, the Nazi regime adopted a law on the promotion of marriages (Gesetz zur Förderung der Eheschließungen). Under this law, loans up to 1,000 RM. may be made to couples. No interest is charged, but 1 percent of the total loan must be paid back every month. One-quarter of the original loan is cancelled for each child born alive.

In 1937, this measure for the stimulation of marriages and births was extended to include women continuing to work after marriage. In such cases, 3 percent of the original loan must be amortized each month. To qualify for marriage loans, husband and wife must meet the racial and political requirements set by the Nazi regime. (For details see RACIAL HYGIENE.)

MATERNAL HEALTH SERVICE (Gesundheitlicher Mütterschutz).

The constitution of the Weimar Republic declared the protection of women in maternity a public concern. Thus, a practice of long standing was reaffirmed and embodied into the law of the land.

Weighty reasons for the development of maternal health service existed in the "old" Germany. In normal times women constituted one-third of the labor force. Significantly, this group has a comparatively high sickness rate. Deliberately induced abortions (Abtreibungen) with a resultant large number of chronic gynecological disorders and deaths were very frequent. (The term "abortion" denotes the termination of a pregnancy before the 18th week or in a stage when the embryo measures less than 32 cm..) Premature births (Frühgeburten), e.g., live births weighing less than 2,500 g., constituted about one-seventh of the total. Stillbirths (Totgeburten), i.e., fetus of at least 35 cm. length, constituted nearly 3 percent of all births, and most of them were caused by narrow pelvis (enges Becken) of the mother. The number of maternal deaths in connection with childbirth and abortion was 52 per 10,000 births in 1930, and 48 in 1935. About half of these deaths were caused by septicemia, and most septicemia cases were the result of illegal abortion. A considerable proportion of deaths in early infancy (Frühsterblichkeit der Säuglinge) was caused by premature birth, diseases of the mother, and birth injuries. These conditions have not only persisted,

but have become worse in recent years when female labor has been utilized to the utmost.

Of the many statutes pertaining to the health protection of women in general, and to maternal health service in particular, four are of major importance.

(1) The law concerning the protection of working mothers of 17 May 1942 (Gesetz zum Schutze der erwerbstätigen Mutter; short title, Mutterschutzgesetz) is the recodification and extension of a measure adopted by the Weimar Republic in 1927. Its provisions are mandatory for all women employed in industry, business, and administration. They may be applied to women in home industry and to the wives and daughters of farmers. The law prohibits employment of pregnant women if the life or health of mother or child is endangered. Particular emphasis is placed on the exclusion of pregnant women from heavy manual work (schwere körperlich Arbeit) and from hazardous work. Requests of women for discontinuation of employment during the last six weeks of pregnancy must be granted. Women must not be employed for 6 weeks after delivery (Entbindung). The period of protection is extended to 8 weeks if the mother nurses her child, and to 12 weeks if she nurses a prematurely born infant. Overtime and

night work are forbidden to women in maternity. The nursing mother is entitled to a total of 90 minutes a day of paid time-off for nursing. Dismissal of women because of pregnancy is not allowed.

(2) The decree concerning hours of work (Arbeitszeitverordnung) contains provisions forbidding the employment of women in nightwork and in a considerable number of designated types of work, including such hazardous occupations as are listed in a series of decrees and regulations.

(3) The compulsory sickness insurance program (Krankenversicherung) includes maternity insurance, the so-called Wochenhilfe. It provides complete prenatal, obstetrical, and postnatal care for the family dependents (Familienangehörige) of insured persons, as well as the female insured (Selbstversicherte). Medical care includes the services of physicians -- specialists as well as general practitioners -- the services of midwives and nurses; hospitalization when indicated; and necessary drugs. In addition to medical care, women in maternity receive cash benefits. Amounts equal to her average earnings are paid to the insured woman over periods of 6 weeks prior to delivery (Entbindung) and of 6 weeks after delivery. The latter period is extended to 8

weeks if the mother is nursing (stillt) and to 12 weeks if she is nursing a prematurely born child. This benefit is called Wochengeld. In addition, a nursing allowance (Stillgeld) of 0.50 RM. a day is paid up to 26 weeks, if the mother proves that she is nursing her child. Family dependents are also entitled to Wochengeld and Stillgeld. Their benefits are lower than those paid to the insured, but must not be less than a fixed minimum per day. Before the war, nearly three-fourths of all women in maternity received the services and cash benefits available under the compulsory sickness insurance program.

(4) The Reich decree of 13 February 1924 concerning public welfare (Verordnung über die Fürsorgepflicht), as amended, provides services and cash benefits identical to those available under social insurance for needy women not covered by social insurance, and declares the costs involved not recoverable (nicht ersatzpflichtig).

Prenatal clinics (Schwangerenfürsorgestellen) are centers of preventive service for mother and child. Organization of the medical aspects of prenatal clinics is one of the functions of the health department. Social and economic aspects fall under the jurisdiction of the child welfare department (Jugendamt). Prenatal clinics

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are conducted as separate institutions in some large cities. They are combined with infant health clinics (Säuglingsfürsorgestellen) in the majority of cities and smaller communities. (See INFANT HEALTH SERVICE.) The principal functions of these clinics include (1) health supervision (gesundheitliche Überwachung) of the pregnant woman; (2) arrangement of financial assistance (wirtschaftliche Hilfe) to those in need; and (3) provision of legal advice (Rechtsberatung), which is particularly important because of the large number of unmarried mothers. (For details see ILLEGITIMACY.)

Institutional care is provided through maternity homes (Mütterheime), special hospitals such as the institutions for the training of midwives (Hebammenlehranstalten), and obstetrical divisions (Entbindungsabteilungen) of general hospitals. It must be noted that home delivery is strongly emphasized. (For details see MIDWIFE.)

Educational work for mothers has been promoted by the Reichsmütterdienst of the N.S. Volkswohlfahrt, and convalescent care by the party-sponsored "Hilfswerk Mutter und Kind"

MEASLES (Masern).

Measles is not included in the list of diseases

reportable throughout the Reich. The disease is so common among children that only its absence comes as a surprise to parents. Deaths from measles are relatively rare -- less than 2,000 a year in the 1930's -- and occur primarily in the first year of life.

MENINGITIS, EPIDEMIC (["]Übertragbare Genickstarre).

Epidemic meningitis is reportable throughout the Reich. The number of reported cases was 663 in 1930; 1,362 in 1935; 7,211 in 1940; 4,767 in 1941; 2,765 in 1942; and 2,550 in 1943. The frequency of epidemic meningitis has increased considerably since the beginning of the war.

Reported deaths numbered 351 in 1930; 649 in 1935; 2,089 in 1940; 1,367 in 1941; and 947 in 1942. As compared with the early 1930's, the mortality from epidemic meningitis increased in 1940 and 1941 but declined in 1942. In the early 1940's it was two to three times as high as in the United States. The case fatality in the period from 1930 to 1942 ranged from a high of 53 percent in 1930 to a low of about 29 percent in 1940 and 1944.

MENTAL HOSPITAL (Heil- und Pflegeanstalt, also called Irrenanstalt).

In 1939, there were 171,522 beds in 252 mental hospitals, or approximately 2.2 beds per 1,000 population. In addition there were 18,783 beds in 52 institutions for persons with mental defects, 2,854 in 57 institutions specializing in the treatment of patients with neuroses and neurological conditions, and 717 in 14 institutions for alcoholics.

The great majority of mental hospital beds are in public facilities, which in general are maintained by large administrative units, the so-called Landes-fürsorgeverbände, and in exceptional cases by large cities. Non-governmental facilities for patients with mental deviations are not uncommon. Most of them are small and limited to the care of certain types or stages of mental illness.

In general, the mental hospitals accept voluntary as well as committed patients. Prerequisite to admission is a medical certificate stating that the patient is mentally sick and requires institutional care. Certification is one of the functions of the health officer (Amtsarzt). In emergencies, however, any physician may

write out the certificate, but must immediately report the case to the Amtsarzt for further action. A person who endangers himself or others (ist sich selbst oder seiner Umgebung gefährlich) may be committed on the basis of a certificate by the Amtsarzt, the medical director of a public mental hospital, or a physician in the psychiatric department of a university hospital. Committed patients may be temporarily or permanently discharged only with the consent of the police authority, i.e., its consultant, the Amtsarzt.

All mental hospitals are supervised by the Amtsarzt. They must be inspected at least once a year. For private facilities two inspections a year are mandatory and, in addition, a visit by a committee consisting of a recognized psychiatrist and the Regierungs- und Medizinalrat (Besuchskommission). Public institutions have full-time staffs as a rule.

Under the Nazi regime, the mental hospitals have been discredited. They were made part of the machinery for the execution of racial laws, in particular the sterilization law; and they applied "mercy killings" on a large scale. (See also RACIAL HYGIENE.)

MENTAL HYGIENE CLINIC (Fürsorgestelle für Psychisch Kranke).

Beginning in 1910, clinics which may be compared with mental hygiene clinics were increasingly established in Germany. The majority were affiliated with and staffed by mental hospitals. By 1930, 36 mental hospitals had a well-organized system of mental clinics, and an additional 32 were building up such service. Outstanding were the clinics maintained by some mental hospitals in Bavaria (Bayern), in particular in Erlangen and in Frankfurt a. M. and in Berlin. In addition, a number of large cities and some counties had assumed responsibility for the operation of mental hygiene clinics as part of their preventive health services. This pattern was developed by the city of Gelsenkirchen. Special child guidance clinics were uncommon.

The functions of mental hygiene clinics included (1) supervision of patients temporarily or definitely discharged from mental hospitals; (2) supervision of patients not in need of hospitalization; (3) the furnishing of consultant service on problems of mental illness and defect to the preventive health clinics, child welfare departments, schools, juvenile courts, vocational

guidance and employment agencies; and (4) education in mental hygiene. Particular attention was paid to the supervision of patients placed with a family other than that of the sick, i.e., the "family care" of mental patients. In 1930, about two-thirds of all mental hospitals utilized the method of family care for patients in stages of recovery.

Since the advent of the Nazi regime, publications no longer refer to mental hygiene clinics. In the absence of information to the contrary, it must be assumed that mental clinics have been supplanted by racial hygiene clinics, an innovation of the Nazi regime. (For details see RACIAL HYGIENE.)

MENTAL ILLNESS (Geisteskrankheit).

The prevalence of mental illness is a matter of conjecture. Estimates made in 1925 on the basis of a nation-wide census put the number of persons with obvious mental diseases and serious mental defects at 369 per 100,000 population. This figure does not include the deaf-mute, blind, or physically handicapped with mental deviation, the many neurotics, and the large number of persons with borderline conditions.

Of the cases of mental defect (Schwachsinn), about a third were attributed to heredity (Erblichkeit), another third to birth injuries, and the rest to a large variety of non-hereditary causes. Of the mental diseases, the majority were classified as hereditary (erbliche Geisteskrankheit), and most of the remainder were caused by alcoholism and syphilis. Alcoholic psychoses disappeared in the -- relatively few -- years during which the consumption of hard liquor, such as Schnaps, and of alcoholic beverages such as wine (Wein) and beer (Bier) was severely curtailed. Syphilitic psychoses tended to decline markedly with the development of venereal disease control programs.

To what extent the picture has changed under the Nazi regime is not known. The racial legislation of the regime, in particular the ruthless application of compulsory sterilization, may have prevented reproduction by parents known to be mentally defective, although this does not necessarily imply a reduction in the number of mentally defective children. A substantial number of persons with mental disease may have died in institutions. On the other hand, an increase in mental deviations in general, and in psycho-neuroses in particular may well result from

the conditions under which the German people have been held by the Nazis and from the war experiences of civilians as well as soldiers.

MIDWIFE (Hebamme).

Midwives are persons with professional training. They play an important part in the German health service for two reasons: they constitute a numerically strong group, and they are extensively utilized for the performance of specific functions under a system which encourages home delivery. Before the war, approximately two-thirds of all births occurred in the family home. In large cities the proportion of hospital births was high, reaching 70 to 80 percent in communities like Bremen, Hamburg, and Berlin. In areas with many rural districts, such as Pomerania, Silesia and Thuringia, only one-seventh of all births occurred in hospitals.

The scope of the functions of midwives is clearly defined by law. Midwives take full charge of normal deliveries, whether in the hospital or in the home. They are obliged to refer every abnormal case to a physician. Their training is focussed on this point, and compliance with the rules is strictly enforced. In actual practice,

midwives on private duty or in the employ of agencies are fully responsible for about three-fourths of all home deliveries, and assist physicians in about one-fourth of such cases. In addition, they participate in prenatal, postnatal, and infant health service provided by clinics. Institutional midwives attend hospitalized cases under the general supervision of staff physicians, and act as assistants to the physicians in case of complications.

Midwife service is organized uniformly on the basis of the Reich law of 21 December 1938 concerning midwives (Reichshebamengesetz), which closely follows the pattern developed long before by the states, and in particular by Prussia.

The following is a summary of pertinent statutes, rules, and administrative procedures in force at present.

Every mother has the right to obtain the services of a midwife. Women in maternity are required to arrange in time for the presence of a midwife at their delivery, and those who have failed to do so must send for the midwife immediately after their confinement. Physicians must see to it that midwives are in attendance at every delivery. The occupation of midwife is restricted to

women approved for such service, (anerkannt als Hebamme). In addition, all but the midwives employed in hospitals must possess a permit to practice, (Niederlassungserlaubnis). This permit is limited to practice in localities with proven need of a midwife. Only women who have passed a state-board examination (staatliche Hebammenprüfung) are eligible for approval (Anerkennung). Prerequisite to the examination is completion of a theoretical and practical training of 18 months at a state-approved institution, the Hebammenlehranstalt, or at another hospital, such as a university hospital, approved for this purpose. Admission to the school is open to women between 18 and 35 years of age who have completed 8 years of schooling (Volksschulbildung).

All midwives are under the supervision of the health officer (Amtsarzt) to whom they must report before settling in a community. The supervision covers performance in general, proper condition of instruments and supplies, promptness and accuracy in reporting fever cases and deaths, completeness of annual reports, and compliance with statutes concerning postgraduate training. Every midwife must take a re-examination every 3 years, and an institutional refresher course of 2 weeks every 5 years.

In 1939, the number of midwives totalled 23,745, or one for every 2,857 persons. It was sufficient to meet ordinary demands. Only 1,296 midwives were employed in hospitals, while 22,440 were in "extramural" service. The latter group assisted in more than one million home deliveries. This means that each midwife outside of hospitals attended an average of 45 births a year.

Many communities employ full-time salaried midwives for home deliveries. These Bezirkshabenmen are particularly common in rural areas and some sections of the country such as South Germany. On the whole, however, private duty midwives predominate. They are guaranteed an annual minimum income by the community (in Prussia, the province is the guarantor). The fees that they are allowed to charge are fixed by a schedule (Gebührenordnung). The main source of income of all non-institutional midwives is payments from sickness insurance organizations (Krankenkassen), which provide for mid-wife service to the insured women and the female dependents of insured men. All midwives are protected by compulsory insurance against accident, old-age, invalidity, and -- if their earnings do not exceed a certain limit -- against sickness. The national organization of midwives set up by the

Nazi regime is the Reichshebammenschaft. Membership in it is mandatory. (See also HOSPITAL and MATERNAL HEALTH SERVICE.)

MINER'S INSURANCE (Knappschaftsversicherung).

All manual workers and the great majority of the salaried employees in the mining industry and related enterprises, called knappschaftliche Betriebe, as well as their family dependents are protected by the Miners' Insurance Act (Reichsknappschaftsgesetz) of 1923 and its numerous amendments. Special legislation, instead of incorporation of the provisions into the Reich Insurance Code (Reichsversicherungsordnung) which covers other groups of the population, was chosen because of special conditions prevailing in the mining industry. Revision of this policy was prepared in 1934.

Three sets of services and benefits available to miners and their family dependents are of considerable importance from the point of view of community health organization.

(1) Complete medical care in case of sickness or maternity is provided for both the insured and their family dependents. In type and scope, the services are

identical with those available under the sickness insurance title of the Reich Insurance Code (see SICKNESS INSURANCE, COMPULSORY), but in amount, some of the services exceed those provided for other groups. Particularly well developed is the program for family dependents (Familienhilfe).

(2) Needed medical care is made available to recipients of disability and old-age pensions (Invaliden-pension, Alterspension) through the machinery of sickness insurance.

(3) Treatment for the prevention of premature disability (Heilverfahren) may be granted. In actual practice, this authorization has been used widely, in particular for the purpose of preventing tuberculosis.

Before the war, 760,000 to 800,000 persons were insured under the Reichsknappschaftsgesetz. The number of family dependents eligible for medical care in case of sickness or maternity probably equalled the first figure. With the steady increase in employment during the war, the total number of persons covered by the act has risen.

Miners' insurance is financed by contributions (Beiträge) of the employees and employers, and by Reich

subsidies from the Reichsstock der Arbeit. These subsidies have become necessary in order to avoid a further increase in the already high rates of contribution.

The administration of sickness insurance and pension insurance under the Reichsknappschaftsgesetz is centralized in the Reichsknappschaft in Berlin-Wilmersdorf. This authority has 20 regional agencies (Bezirksknappschaften) for the direct administration of all services at the local level. The Reichsknappschaft is supervised by the Reich Insurance Office (Reichsversicherungsamt), and belongs to the organizations over which the Reich Ministry of Labor (Reichsarbeitsministerium) has final authority.

MORBIDITY (Erkrankungshäufigkeit).

Accurate information about the frequency and severity of illness in Germany is lacking. By piecing together widely scattered data it is possible to make at least a few general statements on the situation in 1939, and on the marked changes that have occurred during the war.

According to identical observations in many parts

of the country, on any given day before the war approximately 3 percent of the people insured by the compulsory sickness insurance system were unable to work as a result of illness from injury or disease.

Repeated sample studies conducted by the administration of compulsory sickness insurance have shown that before the war the most frequent causes of disability among insured men were injuries (mostly industrial), so-called grippe (mostly colds), muscle rheumatism, and diseases of the upper respiratory tract. Among women, grippe, injuries, sore throat, and gynecological conditions not related to venereal disease were leading in frequency. It must be remembered that all these figures refer to selected groups of working people and to disabling illness only. (See also ACCIDENTS.)

Official figures on the incidence of communicable diseases may easily lead to misinterpretation of the total situation. The most frequent infectious diseases -- venereal diseases -- are not reportable although periodic surveys have been made, and others which are widespread but change in incidence from year to year -- such as influenza, measles, mumps, and sore throat --

are also missing in the list of notifiable diseases.

Judging from figures compiled in the 1930's, syphilis, gonorrhea, and chancroid together constituted the most frequent group of all communicable diseases before the war. In 1934, the new cases were estimated at 225,300 or 343 per 100,000 population. There is reason to assume that the rate had not declined much further prior to the beginning of the war. Undoubtedly, it exceeded those of all other communicable diseases in 1939. (For details see VENEREAL DISEASES.) Ranking after venereal diseases were diphtheria, scarlet fever, whooping cough, and tuberculosis. These five diseases presented the major prewar health problems, if influenza and measles are omitted. Cholera, yellow fever, and plague had become entirely unknown, and small pox, relapsing fever, typhus, trichinosis, and leprosy had practically disappeared. (For details see the respective headings.)

The following table summarizes the data on the incidence of the communicable diseases officially reported in 1939.

Reported Communicable Diseases in Germany, 1939
(Arranged in order of frequency)

<u>Disease</u>	<u>Number of cases</u>	<u>Cases per 100,000 population</u>
Diphtheria	143,228	206
Scarlet fever	128,848	185
Whooping cough	82,068	118
Infectious pulmonary tuberculosis	69,482	100
Skin tuberculosis	1,714	2.5
Other tuberculosis	6,366	9.2
Dysentery	6,306	9.1
Puerperal fever (following delivery)	2,895	8.2
Meningitis, epidemic	5,120	7.4
Puerperal fever (following abortion)	2,129	6.0
Poliomyelitis	3,703	5.3
Paratyphoid fever	3,072	4.4
Typhoid fever	2,733	3.9
Bacterial food poisoning	2,063	3.0
Trachoma	639	0.9
Encephalitis, epidemic	469	0.7
Bang's disease	287	0.4
Malaria	282	0.4
Dog bites (rabies suspected)	146	0.2
Weil's disease	139	0.2
Anthrax	50	0.07
Psittacosis	18	0.03
Leprosy	4	
Trichinosis	3	
Typhus fever	2	
Relapsing fever	1	
Rabies	1	
Smallpox	0	
Yellow fever	0	
Plague	0	
Cholera	0	

Examinations of school children before the war showed a high prevalence of dental caries among the first grades, and a large number of cases of adenoids, lymphatism, scrofulosis, faulty posture, myopia, intestinal parasites, and certain skin infections -- such as impetigo contagiosa -- among all grades, although conditions varied greatly according to the economic circumstances prevailing in various parts of the country. In South Germany, goiter (Kropf) and Basedow's disease (Basedowsche Krankheit) were quite common.

The war has brought with it: (1) a tremendous increase in nearly all diseases and defects that were previously prevalent; (2) a sharp but not dangerous increase in those communicable diseases which had been of secondary importance in the 1930's; (3) the reappearance and spread of communicable diseases rare or non-existent prior to 1939; and (4) a marked impairment of physical and mental health in general. As a result of the large-scale shifting of populations, with resultant dissemination of causative agents and vectors of disease, the usual pattern of disease distribution has changed so profoundly that the old figures are of little

significance now.

Of the communicable diseases frequent before the war, diphtheria and scarlet fever have multiplied, and tuberculosis has increased markedly. No definite statement can be made about venereal diseases and upper respiratory infections.

Communicable diseases that have assumed greater significance since the war include mainly enteric infections such as dysentery, typhoid fever, and para-typhoid fever, and parasitic and infectious skin diseases.

Among the diseases reappearing in scattered locations or becoming more important than before are louse-borne typhus fever, malaria, trachoma, and trichinosis. Infectious hepatitis, extremely rare before the war, and "field nephritis", believed to be caused by microorganisms, have become common. Years of inadequate nutrition, unsanitary living conditions, over-crowding, uncleanliness, over-exertion in war work, lack of proper medical care, and interruption of the activities for health protection are certain to produce in the near future a very heavy demand for the medical care of physical and mental disorders.

MORTALITY (Sterblichkeit).

The death rate in the old Reich was 11.0 per 1,000 population in 1930, 11.8 in 1935, and 12.7 in 1940. It must be assumed that it has continued to rise since that time.

Between 1930 and 1940, live births increased relatively more than deaths. The resulting excess of births over deaths (Geburtenüberschuss), per 1,000 population amounted to 6.6 in 1930, 7.1 in 1935, and 7.3 in 1940. Lately, with rising mortality and sharply declining births, this trend has been reversed. (See also BIRTHS.)

Before the war, by far the most frequent cause of death was diseases of the circulatory system (Krankheiten der Kreislauforgane), most of which were degenerative diseases of advancing age. Second place on the list of major causes of death was held by cancer (Krebs). Other important causes included old-age infirmity (Altersschwäche), inflammation of the lungs (Lungenentzündung) -- a generic term covering a variety of conditions -- and tuberculosis (Tuberkulose).

In normal times, approximately one-third of all deaths occurred in hospitals. (See also INFANT MORTALITY.)

MUMPS (Ziegenpeter).

Mumps is not on the list of diseases reportable throughout the Reich. The disease is common among children.

NON-MEDICAL PRACTITIONER (Heilpraktiker).

Under certain provisions of the Reich trade code (Gewerbeordnung) that were in effect until 1939, men and women without medical licenses were permitted to attend sick persons for pecuniary gain. This was in line with the old doctrine of freedom to engage in trades or occupations (Gewerbefreiheit). However, in the case of non-medical practitioners, this freedom was restricted by law. The statutes concerning social insurance, venereal disease control, and small pox vaccination excluded non-medical practitioners from any service in these fields, and the laws pertaining to drug control and hospital licensing restricted their activity to a minimum. Furthermore, non-medical practitioners were under the strict supervision of the health officer (Amtsarzt). They were obliged to report (Anmeldepflicht) to the health officer, who had to keep a special file for this group. They were forbidden to carry out their occupation by traveling around (im Umherziehen), or to use a title or designation resembling M.D. or Arzt (ärztähnliche Bezeichnung).

With one exception, none of these restrictions has been lifted by the Nazi regime, despite its friend-

liness to persons opposed to "orthodox medicine" (Schulmedizin). On the contrary, in line with ideas advanced time and again in earlier years, the Nazi regime on 17 February 1939 adopted a law designed further to restrict the activities of non-medical practitioners (Gesetz über die berufsmäßige Ausübung der Heilkunde ohne Bestallung, or "Heilpraktikergesetz"). Its main provisions are (1) requirement of a permit for persons not appointed as physicians to attend sick persons for pecuniary gain; (2) prohibition of new admissions to this group; (3) preferential admission to medical schools for persons with "proven ability" in attending sick persons; (4) prohibition of training schools for non-medical practitioners; and (5) requirement for non-medical practitioners to belong to a national organization, the Deutsche Heilpraktikerschaft. The only -- and highly dangerous -- concession the regime has made is the introduction of an official designation, "physician for nature healing" (Arzt für Naturheilkunde), for those permitted to practice.

Before the war, there were approximately 10,000 non-medical practitioners listed or 21 per 100 physicians. Of these, some 3,000 belonged to the Deutsche Heil-

praktikerschaft. Whether the shortage of medical personnel during the war has resulted in greater utilization of non-medical practitioners is not known.

NURSE (Krankenschwester in the case of women and Krankenpfleger in the case of men).

Persons who want to engage in the occupation of nursing must have a permit, according to the national law of 28 September 1938 concerning nursing service (Gesetz zur Ordnung der Krankenpflege). The permit is valid in every part of the country. Requirements to be satisfied by an applicant for a permit include (1) completion of the 18th year of life, 8 years of schooling (Volkschulbildung), and one year of household work in a family, institution, or school prior to admission to the nursing school; (2) evidence of physical and mental fitness (Tauglichkeit) for the profession of nurse; (3) 18 months of training in a state-approved school of nursing (staatlich anerkannte Krankenpflegeschule); and (4) examination by a state board of examiners (staatliche Krankenpflegeprüfung).

Before the new law went into effect, the majority of private duty nurses and most of those serving as

visiting nurses (Gemeindeschwestern) or on the staffs of hospitals other than mental institutions were graduates of approved nursing schools with two years training. Official statistics do not reveal details on this point. It is questionable whether the new regulations have been strictly enforced during the war, in view of the ever increasing shortage of nursing personnel.

The total number of nurses, excluding children's nurses (see CHILDREN'S NURSES), was approximately 135,000 before the war, or one nurse for every 508 persons in the population. Of these, 115,000 were Krankenschwestern. To meet war demands and to relieve trained personnel, large-scale training of nurses aides has been initiated. The youth organizations of the party as well as the Red Cross and the air raid protection service (Luftschutzdienst) have provided for training in first-aid and elementary bedside nursing.

Nearly one-half of all nurses belong to church organizations or religious orders. The protestant church maintains Mutterhäuser und Schwesternschaften der Innern Mission, the nurses being called Diakonissen. The Catholic church supports a variety of orders and

organizations. Their national organization is the Deutscher Caritasverband. Among non-religious groups, the Red Cross nurses (Rote Kreuz Schwestern) play a notable role. The party-sponsored organization is the N.S. Reichsbund Deutscher Schwestern.

All nurses in a locality, whether on private duty or in the service of organizations or agencies, are under the general supervision of the health officer (Amtsarzt), who is obliged to keep records (Listen) of them. Persons employed by hospitals or related institutions are, of course, responsible first to their superiors, but nevertheless fall under the jurisdiction of the health officer if they violate statutes pertaining to the profession of nursing. (See also VISITING NURSE.)

NUTRITIONAL STATUS (Ernährungslage).

From the very beginning of the war, Germany has systematically stripped the occupied territories of food and food products. This policy, in combination with strict rationing of food for civilians in Germany has enabled the Nazi regime to prevent such grave nutritional conditions as developed during the First World War. As the Germans lose their grip on surrounding

countries, the situation may well change profoundly and rapidly.

In the absence of any reliable information, only general statements on the nutritional status of the German people up to the end of 1943 can be made.

The quantity of food for the individual has been reduced, but the caloric value of the food ration in Germany, while less satisfactory than before and considerably below the optimum, is still far above the starvation level enforced in occupied countries. The quality of the food has deteriorated greatly, and this point deserves special attention.

Diseases caused by the consumption of inferior, if not unsafe, food have become more frequent, although not to an extent warranting serious concern. (For details see FOOD POISONING and TRICHINOSIS.) Tuberculosis of the lungs is definitely on the increase. (For details see TUBERCULOSIS.) Substantial weight loss seems to be general among adults and children. Marked retardation of growth of children must be anticipated on the basis of former experience. In contrast to conditions observed in 1917 and 1918, vitamin deficiency diseases,

in particular rickets (Rachitis), may play a minor role in view of the fact that, so far, synthetic vitamins have been distributed liberally.

OCCUPATIONAL DISEASES (Berufskrankheiten).

Since 1925, certain occupational diseases have been reportable throughout the Reich. At present, the official list contains 25 to 30 notifiable occupational diseases. Included are not only poisoning (Vergiftung) by various chemicals, and pneumoconiosis (Staublungen-erkrankung), but also such conditions as infections acquired by health personnel. Reports must be made by the attending physician and are submitted to the industrial physician employed by the state (staatlicher Gewerbeärzt), who is responsible for ensuring adequate medical care. The physician attending a patient with occupational disease is obliged to accept re-examination (Nachunter-suchung) and advice by designated physicians with special experience in the fields concerned.

Before the war, infectious diseases (Infektions-krankheiten), silicosis (Silikose), and lead poisoning (Bleivergiftung), in that order of sequence, together constituted nearly half of all reported cases of occupational diseases. The most frequent causes of temporary disability were silicosis and infectious diseases. Silicosis accounted for about four-fifths of all cases of permanent disability. (See also INDUSTRIAL HYGIENE.)

OPHTHALMIA NEONATORUM (Blennorrhœ or Augentripper
der Neugeborenen).

Gonococcic infection of the eye at birth was one of the major causes of blindness in the past. The frequency of this disease declined sharply after the midwives in many parts of the country were required by law to instill silver nitrate into the eyes of every newborn attended (Credeisierung). However, because of incomplete application of this prophylactic method, the disease has not been wiped out. On the basis of surveys it was estimated that some 1,600 cases of Blennorrhœ occurred in 1927 and some 700 in 1934.

OUT-PATIENT DEPARTMENT (Poliklinik).

Polikliniken are institutions providing diagnosis and treatment for ambulatory patients with little or no income (die Unbemittelten), thereby supplementing the services available under social insurance and public welfare. All university hospitals (Universitätskliniken) maintain highly specialized out-patient units which are extensively used for teaching purposes. The same is true of large city hospitals (städtische Krankenhäuser). Organized out-patient service is less developed at the

county hospitals (Kreiskrankenhäuser), although there are exceptions to this rule. Many non-profit voluntary hospitals also provide for service to ambulatory patients.

Ever since out-patient departments were established, they have been accused by the medical profession of encroachment upon private practice. This opposition on the part of physicians resulted in the early establishment of rather stringent requirements for eligibility to treatment at out-patient departments. Since the early twenties, emphasis has been placed on the utilization of insurance practitioners (Kassenärzte) and welfare physicians (Wohlfahrtsärzte) on the basis of the free choice system. During the war, this policy may have been reversed to some extent.

An institution essentially of the same type as the Poliklinik is the Krankenkassen-Ambulatorium. It differs from the Poliklinik in two respects: it is not part of a hospital, and it is staffed with salaried health personnel working on the basis of group practice. Prior to 1933, Ambulatorien were operated by sickness insurance organizations in a number of large cities. They established a fine record of adequate, convenient, and economical service, but they were bitterly fought by private practi-

tioners, who were afraid of the competition of these well-equipped and well-staffed institutions. Yielding to the influence of physicians in the party, the Nazi regime has discontinued the operation of Ambulatorien by sickness insurance organizations, and based medical service exclusively on the panel system (see SICKNESS INSURANCE, COMPULSORY.)

PARATYPHOID FEVER (Paratyphus).

Paratyphoid fever is reportable throughout the Reich. The German term Paratyphus is applied to a variety of conditions without clear distinction as to etiology. Reported cases numbered 4,979 in 1930; 2,725 in 1935; 4,197 in 1940; 4,883 in 1941; 6,078 in 1942; and 5,058 in 1943. The number of cases per unit of population has not changed significantly. In frequency, paratyphoid B far exceeds paratyphoid A. Before the war, the disease occurred comparatively frequently in the southwestern region of Germany.

Deaths from paratyphoid fever totalled 146 in 1930; 118 in 1935; 183 in 1940; 156 in 1941; and 187 in 1942. In the period from 1930 to 1942, the death rate per 100,000 population has remained close to 0.2, and the case fatality has ranged from 3 to 4 percent.

Special control measures include (1) immunization; (2) authorization for the health officer (Amtsarzt) to isolate the sick and suspected cases, against their will if necessary; (3) the exclusion from school of sick teachers and pupils, of suspected cases, of carriers (Dauerausscheider), and of persons living in a household with a case of paratyphoid; (4) readmission to

school of persons who have been sick only after three negative stool and urine tests (Stuhl- und Urinuntersuchungen) taken at 8-day intervals, and of carriers after certification by the health officer; and (5) the exclusion of carriers (Dauerausscheider) from any occupation in the food industry (Lebensmittelindustrie), in certain centers of food trade, such as butcher shops (Metzgereien) and bakeries (Bäckereien), and in the production and distribution of milk, if this involves contact with the product. (See also COMMUNICABLE DISEASE CONTROL and FOOD CONTROL.)

PENSION INSURANCE (Pensionsversicherung, also called Rentenversicherung).

A characteristic feature of the German social security program is the compulsory pension insurance system. It protects designated groups of the population against the economic hazards of permanent disability (dauernde Invalidität), serious but temporary disability (vorübergehende Invalidität), and old age (Alter), i.e., the period after completion of the 65th year of life. In addition, it provides for the support of the widows, widowers, and orphans of insured persons.

The pension insurance system comprises four special programs, all of which are nation-wide:

(1) Workers' invalidity insurance (Invalidenversicherung), one of the programs included in the Federal Insurance Code(Reichsversicherungsordnung), covers workers (Arbeiter), domestic servants (Hausgehilfen), and a few other specified groups of relatively smaller size. In 1939, more than 19,700,000 persons were insured under this program. Administrative responsibility is vested in special bodies, the Landesversicherungsanstalten, which in general cover the territory of a state or of large administrative districts within the state, such as the provinces (Provinzen) in Prussia. These bodies are supervised by the Reich insurance office (Reichsversicherungsamt).

(2) Pension insurance for salaried employees (Angestelltenversicherung), regulated by the Angestelltenversicherungsgesetz, covers primarily salaried employees, but also a number of self-employed persons such as midwives in private practice. All persons earning less than 7,200 RM. per year are required to be insured, (sind versicherungspflichtig). In 1939, their number amounted to about 4,700,000. Administration of the program is

centralized in the Reichsversicherungsanstalt für Angestellte in Berlin, which is under the general supervision of the Reich Insurance Office (Reichsversicherungsamt).

(3) Miners' pension insurance (knappschaftliche Pensionsversicherung) is part of the special provision made under the Reichsknappschaftsgesetz for both workers and salaried employees in the mining industry. In 1939, about 800,000 persons were covered by the program. The administrative agency is the Reichsknappschaft in Berlin-Wilmersdorf, which maintains 20 regional offices (Bezirksknappschaften). It is supervised by the Reich Insurance Office (Reichsversicherungsamt).

(4) Independent craftsmen's old-age insurance (Altersversorgung des deutschen Handwerks) is a recently established program for the protection of self-employed craftsmen. In 1939, it covered 1,500,000 persons. Its administration is placed under the Reichsversicherungsanstalt für Angestellte.

In addition to providing for a minimum of economic security through payment of cash benefits of various types, the first three pension-insurance programs contribute substantially to the promotion of public health and

to direct health service for insured persons. They allot funds for the support of community facilities and services, such as preventive clinics and visiting nurse service (Gemeindekrankenpflege), maintain preventive clinics of their own, such as tuberculosis and venereal disease clinics, and operate a large number of tuberculosis sanatoria (Heilstätten), convalescent homes (Erholungsheime), and related institutions for use by the eligible groups. Although not mandatory, these activities are carried out on a large scale. The Invalidenversicherung, for instance, in 1939 assumed financial responsibility for the "preventive treatment" in institutions (Heilverfahren) of some 150,000 persons. (See also SOCIAL INSURANCE.)

PHARMACIST (Apotheker).

The professional designation Apotheker may be used only by persons officially appointed (bestallt) as pharmacists. Before obtaining an official appointment (Bestallung), the candidate must meet many requirements. After graduation from Gymnasium, Realgymnasium, or an equivalent institution, he must complete two years of preparatory practical work as apprentice (Praktikant)

in an approved teaching pharmacy (Lehrapotheke). Only 7 to 8 percent of all pharmacies are approved for teaching purposes, a policy which serves not only to ensure proper training, but also to limit the number of students. At the end of the practical training a first examination, the pharmazeutische Vorprüfung, must be passed. Following this, university study of at least 6 semesters (Halbjahre) must be completed and a final examination (pharmazeutische Prüfung) be passed. Finally one year of practical work as assistant to a pharmacist is required, half of which -- the soziales Berufshalbjahr -- has to be carried out in a small community.

Before the war, about 16,300 pharmacists, including about 1,200 apprentices (Praktikanten) were available, or about 1 pharmacist for every 5,000 persons. One in every six pharmacists was female. Pharmacists owning or operating pharmacies were evenly distributed, with the result that rural areas were as well supplied through rural pharmacies (Landapotheken) as cities were through city pharmacies (Stadtapotheken). In the event of substantial war casualties among pharmacists, a considerable, although not serious, personnel problem might well develop.

The ethical and economic aspects of the pharmaceutical profession are regulated by the nation-wide pharmacists' code (Reichsapothekerordnung). All pharmacists, regardless of their position, must belong to a national professional organization, the Reich Pharmacists' Chamber (Reichsapothekerkammer), which has disciplinary authority over all pharmacists and is supervised by the Reich Ministry of the Interior (Reichsministerium des Innern). At the local level, the functions of this organization are performed by district chambers (Bezirksapothekerkammern). For the trial of pharmacists on charges related to professional conduct, special professional courts (Berufsgerichte) are established locally and centrally.

The greater part of the income of pharmacists operating pharmacies of their own comes from payments by social-insurance organizations, in particular the various Krankenkassen. Because of the great volume of drug sales to persons eligible for service under social insurance, the pharmacists must give a discount of 7 percent on all bills submitted to Krankenkassen and similar agencies.

Supervision of pharmacists is very strict.

For details see PHARMACY.

PHARMACY (Apotheke).

The pharmacy is a strictly professional enterprise. It carries drugs (Arzneien) and medical supplies and, in addition, cosmetics and toilet articles of various kinds, but it does not sell any other goods.

The establishment, purchase, or lease of a pharmacy is subject to licensing (Konzession) by the authority supervising the localities, generally the Regierungspräsident. The qualifications to be met in obtaining a license are uniform throughout the Reich. Details can be found in Grundsätze für die Verleihung von Apothekenkonzessionen.

The operation of a pharmacy is regulated by the Apothekenbetriebsordnung, which contains detailed rules as to the number, type, and equipment of rooms; the storage of various drugs; dispensing; and duties and functions of the pharmacist and other personnel. The maximum prices to be charged by pharmacies are fixed by the drug schedule, the Deutsche Arzneitaxe.

Main pharmacies (Stammapotheken) may obtain permission temporarily to maintain branch pharmacies

(Zweigapotheken) if needed. As a general rule, public and non-profit voluntary hospitals have pharmacies of their own for service to hospitalized patients and hospital personnel only. Physicians practicing in rural areas where there are no pharmacies within easy travel distance are permitted to dispense certain drugs to their patients, provided they have passed a special examination and received authorization to have an ärztliche Hausapotheke. The number of physicians holding such permits has declined with the wider distribution of pharmacies.

An elaborate system of supervision of pharmacies serves to maintain standards of service. The higher authority is charged with responsibility for inspecting and appraising each pharmacy in a Regierungsbezirk at least once every 3 years (amtliche Besichtigung). In addition, the health officer (Amtsarzt) must supervise the pharmacies in his district, with special emphasis on public health aspects of their work, and visit them at least once a year (Apothekenmusterung). (See also DRUGS and DRUG TRADE.)

PHYSICIAN (Arzt).

The term Arzt denotes a professional person possessing an official "appointment as physician" (Bestallung als Arzt). The appointment is made solely by the Reich Ministry of the Interior (Reichsministerium des Innern), and has validity in every part of the Reich. It entitles the holder to take up independent practice only after the additional requirements described below are met. The degree of doctor of medicine is of secondary importance, legally and administratively. It is conferred upon presentation of a written dissertation and oral examination.

The professional education of physicians has recently been changed in several respects. The new regulations issued 17 July 1939 became operative 1 August 1939, with the exception of a few which went into effect 1 April 1940. The vast majority of the German physicians received their professional education on the basis of the "Prüfungsordnung für Ärzte" that was in force until 1939, and the new plan was applied with modifications owing to the war. Therefore, both the old and the new requirements for appointment as physician will be presented in summary form.

Requirements for Appointment as Physician

Prior to 1939	'	Since 1939
1. Completion of nine years of education at a higher institution of learning (<u>höhere Lehranstalt</u>)	'	1. The same
2. No practical work prior to university study (<u>Hochschulstudium</u>)	'	2. Six months of service as nurse's aide (<u>Krankenpflegedienst</u>) prior to university study
3. Five semesters of pre-clinical studies (<u>vorklinisches studium</u>) at a university school of medicine	'	3. Four semesters of pre-clinical studies. Six weeks of work in a factory or on the farm (<u>Fabrik- oder Landdienst</u>) during university vacations at the end of the third semester
4. First examination (<u>ärztliche Vorprüfung</u>)	'	4. The same
5. Six semesters of clinical studies (<u>klinisches Studium</u>) at a university school of medicine.	'	5. The same
6. Practical work in hospitals or clinics advocated but not required.	'	6. A total of six months of service as "famulus" in approved hospitals and clinics during university vacations at the end of the seventh and ninth semesters
7. Final examination (<u>ärztliche Prüfung</u> or <u>Staatsexamen</u>)	'	7. The same

Requirements for Appointment as Physician (con't.)

Prior to 1939	Since 1939
8. One year of internship (<u>Medizinal-praktikantenjahr</u> or <u>praktisches Jahr</u>) at an approved hospital	8. Abolished (see 10 and 11)
9. Appointment as physician and license to practice.	9. The same, but permit to practice independently subject to requirements listed under Nos. 10 and 11.
	10. One year of service as assistant (<u>Pflichtassistent</u>) in a hospital, or as assistant to a practitioner approved for post-graduate training.
	11. Three months of practical work as assistant to or substitute for a rural insurance practitioner (<u>Landvierteljahr</u>)

The quality of medical education has deteriorated rapidly since 1933. Research work, formerly strongly emphasized, has been relegated to a secondary place. Many outstanding teachers have been dismissed and replaced by mediocre men or Party stooges. Lectures on Party ideology, physical training, Party activities, and military exercises have taken a good deal of the time of medical students. In selecting students, rating their performance during the study years, and passing judgment on examination results, political activities have been

put above personal qualifications and factual knowledge.

Before the war a total of 59,454 physicians were reported in Germany. Of these, 29,390 or 49.5 percent were insurance practitioners (Kassenärzte); 3,933 or 6.6 percent were in practice without being admitted to insurance practice; 21,066 or 35.4 percent were civil servants (angestellte und beamtete Ärzte) or officers in the medical corps of the armed forces (Sanitätsoffiziere); and 5,065 or 8.5 percent were not in practice.

The figures given above refer to all physicians. Additional information will serve to show the availability of physicians for direct service to the civilian population before the war. Excluding health officers, physicians exclusively engaged in preventive health work, research workers, Sanitätsoffiziere, and retired physicians, there were 47,725 physicians or 1 for every 1,432 persons. This figure includes 3,636 women doctors, (Ärztinnen), representing 7.6 percent of all. The geographic distribution of physicians in active practice was very uneven. In rural areas the number of doctors per unit of population was about half that in cities. However, the area served by the average rural doctor was only 27 sq. km., indicating that the problem of rural service was primarily one

of transportation. Of the 47,725 physicians, 14,992 or 31.4 percent were approved as specialists (Fachärzte). Women doctors accounted for about one-third of all certified pediatricians. The following table gives a summary of the officially recognized specialties, the years of postgraduate study required for certification as specialist, and the number of physicians with a certificate as specialist (Facharztanerkennung). It must be noted that any physician other than one officially approved as specialist is forbidden to designate himself as "Facharzt", and that a specialist ordinarily cannot be a family doctor (Hausarzt).

Specialty	Years of postgratuate study re- quired	Number of specialists as of 1939
Surgery (<u>Chirurgie</u>)	4	2,455
Gynecology and obstetrics (<u>Frauenkrankheiten und Geburtshilfe</u>)	4	1,802
Orthopedics (<u>Orthopädie</u>)	2	390
Ophthalmology (<u>Augenkrankheiten</u>)	2	1,252
Oto-laryngology (<u>Hals-, Nasen- und Ohrenkrankheiten</u>)	2	1,457

Specialty	Years of postgraduate study re- quired	Number of specialists as of 1939
Skin and venereal Diseases (Haut- und Geschlechts- krankheiten)	2	1,376
Urology (Erkrankungen der Harnorgane)	4	196
Nervous and mental diseases (Nerven- und Geistes- krankheiten)	2	1,404
Roentgenology and light-therapy (Röntgen- und Lichtheilkunde)	2	372
Dental, mouth and jaw diseases (Zahn-, Mund- und Kiefer- krankheiten)	2 (plus grad- uation as dentist)	209
Internal medicine (Innere Medizin)	4	2,348
Stomach, intestinal, and metabolic diseases (Magen-, Darm- und Stoffwechselkrankheiten)	4	131
Pulmonary diseases (Lungenkrank- heiten)	4	572
Pediatrics (Kinderkrankheiten)	4	1,028

The professional duties, functions and rights of physicians are set forth in the national physicians code, the Reichsärzteordnung, which is built on two

major planks: (1) the practice of medicine is not a trade (Gewerbe), and (2) the physician is the servant of the people (Diener des Volksganzen). Violators of the code are tried before a professional court, the Ärztliches Berufsgericht.

All physicians except medical officers of the armed forces must be members of a national organization of physicians, the Reich Chamber of Physicians (Reichsärztekammer), a corporation of public law.

The Reichsärzteordnung, Ärztliches Berufsgericht, and Reichsärztekammer were introduced by the Nazi regime and greatly abused for political purposes. However, the basic principles of such organization have long been advocated by medical leaders, and some have been applied for decades.

Supervision of physicians at the local level is a responsibility of the health officer (Amtsarzt). Every physician settling in a locality or moving within a district must report to the health department, which keeps records showing the residences, offices, office hours and qualifications of all doctors in the district.

It is certain that there will be a serious

shortage of competent physicians for many years after the conclusion of the war. The standards of the classes graduating between 1935 and 1939 were poor, but those of the war graduates are still lower. Post-graduate study, formerly well organized, has been brought to a standstill. Many physicians who have been commissioned officers in the army or in charge of health service for party organizations possess little of the knowledge and skill necessary for a good practitioner.

Whether, in addition to the lack of well-trained physicians, a numerical inadequacy may be expected is uncertain at the present moment. The following factors must be taken into consideration: (1) since the early 1930's the number of students entering medical school has declined steadily; (2) since the late 1930's there has been a marked increase in the number of women doctors and in graduations under an accelerated curriculum; (3) casualties among physicians serving with the armed forces or in practice may have been substantial; and (4) after the conclusion of the war, many thousands of physicians, who in peace time had been officers in the medical corps of the armed forces (Sanitätsoffiziere) or had been employed by the numerous Party organizations,

will try to go into private or insurance practice. To what extent additions to the ranks of the practitioners will balance actual losses cannot be estimated because of the lack of accurate information.

POLIOMYELITIS, EPIDEMIC (Epidemische Kinderlähmung).

Epidemic poliomyelitis is reportable throughout the Reich. Small outbreaks of this disease, particularly during the late summer months, were the rule in Germany before the war, and this situation has not changed much during the war. Reported cases numbered 1,363 in 1930; 2,143 in 1935; 2,149 in 1940; 5,306 in 1941; 3,932 in 1942; and approximately 2,900 in 1943. Because of substantial increases in the reporting area, the later figures are not comparable with the earlier ones. There was an increase in the frequency of poliomyelitis, but it was moderate.

Deaths from poliomyelitis numbered 136 in 1930, 197 in 1935, 230 in 1940, and 413 in 1942, indicating a moderate rise in the death rate. It appears from these figures that the case fatality has been fairly constantly in the neighborhood of 10 percent.

PROSTITUTION (Prostitution).

Until 1927 prostitution was officially sanctioned although legally forbidden. According to the Reich Criminal Code (Reichsstrafgesetzbuch), it was a punishable offense for a woman to offer herself for indiscriminate sexual intercourse in return for money (gewerbsmässige Unzucht treiben). Nevertheless, prostitution was not prosecuted if the woman in question registered with the police and complied with the rules for her supervision (sitten-polizeiliche Aufsicht). This system of regulation (Reglementierung) was carried out through (1) supervision of the behavior of women on the streets (Strassen) and in eating and drinking places (Lokale), and (2) the periodic physical examination of all prostitutes on the register, with different examination intervals for the "danger categories" (Gefahrengruppen). Brothels (Bordelle), although officially forbidden, were tolerated. Regulation was applied exclusively to women, and only in so far as they derived the means for their support from prostitution. The result was that an insignificant fraction of the promiscuous men and women became known, that women prostituting themselves were driven underground to become forever the tools of racketeers, and that the transmission

of venereal diseases was not prevented.

General recognition of this absurd situation led to the revision, in 1927, of the obsolete statutes. The regulation of prostitution, with its system of periodic health examination, was abolished. In its place, a new nation-wide system of health service for the control of venereal disease was created. (See VENEREAL DISEASE CONTROL.) The new statutes made it a misdemeanor for anybody, male or female, regardless of social position, publicly to solicit illicit sexual intercourse in a manner violating morals and decency (Werbung für Unzucht durch Sitte und Anstand verletzendes Benehmen). Commercialized fornication (gewohnheitsmäßige Unzucht zum Zwecke des Erwerbes) was prohibited in close proximity to churches and schools, in apartments where children were living, and in communities with fewer than 20,000 population. Brothels and similar houses, such as the so-called "massage parlors", and the operation of special streets and red-light districts -- a system called Kasernierung -- were forbidden. Police functions were confined to assisting the official health departments in operating the health service, to the maintenance of order on the streets, and to the protective custody of people without shelter and of youths in danger of becoming delinquent.

The Nazi regime, asserting a tremendous rise in "immoral behavior" has reversed this development. It reintroduced periodic health examinations of known prostitutes once a week, and strengthened the powers of the police in supervising streets and restaurants for manifestations of immoral behavior.

PUBLIC HEALTH NURSE (Gesundheitsfürsorgerin).

Public health nurses in the American sense do not exist in Germany. Instead, there is a special type of personnel, the Gesundheitsfürsorgerin or Gesundheitspflegerin, a cross between public health nurse and medical social worker.

The professional education of the Gesundheitsfürsorgerin follows a fairly uniform pattern throughout the Reich. After one year of study at an approved school of nursing or institution for the training of children's nurses, two years of study at an approved school of social work (soziale Frauenschule, formerly often called Wohlfahrtschule) must be completed, and an examination must be passed. This is followed by one year of field work, called Probeyahr in der praktischen Sozialarbeit. On successful completion of the year of practical work,

the candidate receives a certificate as "staatlich anerkannte Wohlfahrtspflegerin".

Gesundheitsfürsorgerinnen are usually attached to health departments, preventive health clinics, or the school health service. In some instances they are assigned to welfare departments. They make home visits and assist at clinic sessions, emphasizing social case work and health education. Bedside nursing of the sick does not fall into the province of the Gesundheitsfürsorgerin, but is done by community nurses (Gemeindekrankenpflegerinnen) or private-duty nurses. (See VISITING NURSE.)

PUERPERAL FEVER (Kindbettfieber).

Puerperal fever is notifiable throughout the Reich. Official statistics distinguish between puerperal fever following delivery (Kindbettfieber nach Geburt) and puerperal fever following abortion, (Kindbettfieber nach Fehlgeburt). As the accuracy of diagnosis and completeness of reporting are particularly hard to obtain in conditions as involved as those relating to abortion, statistical data on puerperal fever are necessarily open to question.

The number of reported cases of puerperal fever following delivery was 4,389 in 1930; 4,214 in 1935; 3,552 in 1940; 2,876 in 1941; and 2,161 in 1942.

Reported cases of puerperal fever following abortion numbered 2,612 in 1930; 2,990 in 1935; 1,930 in 1940; 1,936 in 1941; and 1,590 in 1942. In view of the great efforts of the Nazi regime to suppress illegal abortion, it is interesting to note that a considerable number of complications arising out of abortion are officially reported. However, the figures given do not bear out recent statements by official spokesmen complaining about the terrifying increase in illegal abortions.

Reported deaths from puerperal fever following delivery totalled 1,024 in 1930; 904 in 1935; 777 in 1940; 635 in 1941; and 541 in 1942. In the 1930's, one-fifth to one-fourth of all deaths in childbirth were caused by septicemia (Sepsis).

Deaths from puerperal fever following abortion were given as 1,079 in 1930; 661 in 1935; 317 in 1940; 330 in 1941; and 355 in 1942. Interpretation of these figures is complicated by the fact that nothing is known about the extent to which, in recent years, death

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certificates have been filled out by physicians and the question "primary cause of death" has been answered reliably. (See also MATERNAL HEALTH SERVICE.)

RABIES (Tollwut).

Bites by animals suspected of rabies (Bissverletzungen durch tolle oder tollwutverdächtige Tiere) as well as cases of rabies are reportable throughout the Reich. Just as during the war of 1914-1918, reported bites have multiplied in recent years. In 1930 and 1935, they numbered 108 and 78 respectively, but they rose to 2,099 in 1940 and to 1,136 in 1941. The number of deaths from rabies, however, was small. They amounted to 18 and 6 in 1940 and 1941, respectively.

Suspected cases of rabies are subject to observation (Beobachtung), according to the law concerning communicable disease control, i.e., the health officer (Amtsarzt) may take any step deemed advisable. Specific treatment is available at four special institutions, the Wutschutzstationen or Pasteur Institutes located in Berlin, Breslau, Dresden, and Hamburg.

RACIAL HYGIENE (Rassenhygiene).

It is assumed that with the occupation of Germany all statutes directly or indirectly related to the Nazi "racial hygiene" will be revoked. What poses a great administrative problem is the fact that the Nazis have

applied their racial ideas to the organization and operation of health services with such thoroughness that much determined effort and considerable time will be needed to eliminate the last vestiges of their practices.

The objective of the Nazi regime was to create a superior race by eliminating from reproduction all persons supposed to hinder the attainment of the racial ideal, and by promoting the reproduction of "hereditarily healthy" (erbgesunde) and racially valuable (rassisch wertvolle) individuals. The Nazis denied the equality of men, emphasized the inheritability of mental and physical constitution, and declared that "a nation does not consist of individuals but of lineages". This theory guided all legislation in the field of health service. Five of the specific laws dealing with racial hygiene will be summarized briefly.

(1) The Reich law of 14 July 1933 (Gesetz zur Verhütung erbkranken Nachwuchses) authorizes the compulsory as well as voluntary surgical sterilization (Unfruchtbarmachung) of persons with hereditary illness (Erbkrankheit), if there is a great probability of hereditarily sick offspring. It lists eight mental and physical diseases and defects and serious alcohol

addiction as falling under the law. Requests for sterilization may be made by the health officer (Amtsarzt), or by the medical director of a hospital (Anstaltsleiter). By subsequent decrees the obligation of hospitals to file such requests in certain cases has been established; all physicians are ordered to report to their health officer any cases of hereditary illness observed in their practice, and health officers are charged with comting all institutional facilities for candidates for sterilization. In 1934, some 56,000 sterilizations were ordered by the special courts (Erbgesundheitsgerichte) set up for the execution of the law, and most of them applied to cases of feeble-mindedness (angeborener Schwachsinn). Significantly publication of figures has been discontinued since 1934. Since the beginning of the war sterilization has been confined to the so-called "most urgent" cases.

Prior to the Nazi regime, the Reich Penal Code (Reichsstrafgesetzbuch) stipulated that any sterilization performed without the consent of the person involved constituted a serious bodily injury (Schwere Körperverletzung) and a punishable offense. Whether sterilization with the consent of the patient was permissible on the basis of social or eugenic indications was debated.

(2) The Reich law of 1 June 1933 concerning the promotion of marriages (Gesetz zur Förderung der Eheschliessungen) provides for loans to married couples (Ehestandsdarlehen). (For details see MARRIAGE LOANS.) Such loans are not granted if one of the spouses (einer der beiden Ehegatten) has an inheritable mental or physical defect (vererbliches, geistiges oder körperliches Gebrechen). The language of the law allows for considerable latitude in interpreting the term "inheritable defect", and the administrative agencies have capitalized on this fact.

(3) The Reich decree of 15 September 1935 concerning allowances to large families (Verordnung über die Gewährung von Kinderbeihilfen an kinderreiche Familien) provides for financial assistance to families free of hereditary mental and physical disorders. (For details see FAMILY ALLOWANCES.)

(4) The Reich law of 15 September 1935 concerning the protection of German blood and honor (Gesetz zum Schutze des deutschen Blutes und der deutschen Ehre) prohibits marriage as well as sexual intercourse between Jews and nationals of German or related blood. According to the official commentator, all European peoples are blood-related to the Germans, while Jews and gypsies are

of foreign blood.

(5) The Reich law of 18 October 1935 concerning the protection of the racial health of the German nation (Gesetz zum Schutze der Erbgesundheit des deutschen Volkes or Ehegesundheitsgesetz) makes marriage contingent upon a certificate by the health officer (Amtsarzt) or a designated physician to the effect that the engaged are healthy in general and of healthy stock and "pure race" in particular. The health department is charged with issuing the certificate of fitness for marriage (Ehetauglichkeitzeugnis) in cases where the evidence is accepted as satisfactory. According to the law, the certificate is refused if one of the engaged has a disease in an infectious stage, any of the hereditary mental and physical defects listed in the sterilization law, or other mental disorders rendering marriage "undesirable" (unerwünscht) from the national point of view. Execution of the intricate provisions of the law presented so many difficulties that more and more groups were exempted and many of the original practices discontinued.

This special legislation was accompanied by a revision of all statutes related to health service and social security, to bring them in line with racial

hygiene doctrines. The Reich law of 3 July 1934 concerning the unification of health administration (Gesetz über die Vereinheitlichung des Gesundheitswesens) gave a prominent place to the promotion of racial hygiene by health departments and made the establishment of racial hygiene clinics (Beratungsstellen für Erb- und Rassenpflege) in every district mandatory. These clinics are responsible for furnishing "expert advice" on all problems of hereditary health (Erbgesundheit) and purity of race (Rassereinheit).

At the national level, an advisory committee on population and race policy (Sachverständigenbeirat für Bevölkerungs- und Rassenpolitik) was created to assist the Reich Ministry of the Interior in formulating policies and procedures.

RED CROSS, GERMAN (Deutsches Rotes Kreuz).

The Red Cross has long played a significant part in German health service. In 1937, it was given broader powers, apparently in preparation for the war, and in 1943 it was charged with sole responsibility for organization of first-aid and ambulance service for civilians. Under the Nazi regime the Red Cross has become virtually a party organization.

According to its bylaws, the German Red Cross has the following major functions: (1) enrollment and uniform training of (a) male and female personnel active in the Red Cross organizations, and (b) nurses and nurse's aides organized in the Schwesternschaften vom Roten Kreuz; (2) organization of first-aid service in connection with the gas and air-raid protection system (Gas- und Luftschutz); (3) assistance to war prisoners (Kriegsgefangene) and war veterans (Kriegsbeschädigte); (4) operation of first-aid and ambulance service (Rettungsdienst) for the civilian population; and (5) assistance in grave emergencies. (aussergewöhnliche Notstände).

At the local level, the Red Cross maintains (1) first-aid squads composed of trained volunteers (Sanitätskolonnen) and directed by physicians (Kolonnenärzte), and (2) women's auxiliaries, often called Vaterländische Frauenvereine. The local chapters are constituents of county-wide associations (Kreisvereine), and these, in turn, are subordinated to provincial or state associations (Provinzialverbände, Landesverbände). At the top of the hierarchy is the central administration (Hauptverwaltung). The German Red Cross as a whole is under the general supervision of the Reich Ministry of the Interior (Reichs-

ministerium des Innern).

The Red Cross maintains a central storage and supply house in Neubabelsberg (near Berlin), which furnishes all equipment for its first-aid squads and carries in stock such items as demountable barracks for use in emergencies. (See also AMBULANCE SERVICE, FIRST-AID SERVICE, AND NURSE.)

REICH ADVISORY COUNCIL ON PUBLIC HEALTH (Reichsausschuss für Volksgesundheitsdienst).

The Reich Advisory Council on Public Health is composed of national voluntary health agencies and acts as advisor to the Reich Ministry of the Interior to which it is subordinated. It is presided over by the director of the health division of the Ministry.

The council is organized in two main divisions (Hauptabteilungen). The first division includes organizations active in the field of population policy and racial hygiene. It is a purely political body, slightly disguised by the inclusion of some scientific or pseudo-scientific societies such as the German Society for Racial Hygiene (Deutsche Gesellschaft für Rassenhygiene). The

second division comprises national organizations representing various fields of health activity. They are (1) the Reich Association for Mother and Child (Reichsarbeitsgemeinschaft für Mutter und Kind); (2) the Reich Association for the Campaign against Crippling Conditions (Reichsarbeitsgemeinschaft zur Bekämpfung der Krüppeltums); (3) the Reich Tuberculosis Committee (Reichstuberkulose-Ausschuss); (4) the Reich Cancer Committee (Reichsausschuss für Krebstbekämpfung); (5) the Reich Association for the Campaign against Venereal Diseases (Reichsarbeitsgemeinschaft zur Bekämpfung der Geschlechtskrankheiten); (6) the Reich Association for the Campaign against Alcohol and Narcotic Drug Addiction (Reichsarbeitsgemeinschaft für Rauschgiftbekämpfung); (7) the Reich Nutrition Association (Reichsarbeitsgemeinschaft für Volksernährung); (8) the Reich Hospital Association (Reichsarbeitsgemeinschaft für das Krankenhauswesen); (9) the Reich Association for Drugs and Appliances (Reichsarbeitsgemeinschaft für das Arznei- und Heilmittelwesen); (10) the Reich Association for First Aid and Ambulance Service (Reichsarbeitsgemeinschaft für das Rettungswesen); and (11) the Reich Association for Occupational Hygiene (Reichsarbeitsgemeinschaft für berufliche Gesundheitsführung).

REICH HEALTH OFFICE (Reichsgesundheitsamt).

The Reich Health Office is a technical agency subordinate to the Reich Ministry of the Interior (Reichsministerium des Innern). Its functions include (1) research, and (2) technical advice to the Ministry of the Interior, through so-called Gutachten. It is organized in ten divisions (Abteilungen) dealing with general administration; human medicine; veterinary medicine; racial biology and hygiene; chemistry, including food chemistry; the hygiene of water, soil, and air; the hygiene of work; physiology and pharmacology; drugs; and biochemistry.

The office publishes a periodical, the Reichsgesundheitsblatt, which contains important factual information on health matters, including current statistics.

The president of the Reichsgesundheitsamt also directs two special institutions, the Institut Robert Koch and the Landesanstalt für Wasser-, Boden-, und Luft-Hygiene, both of which are primarily engaged in research work in certain fields of hygiene.

REICH MINISTRY OF ECONOMICS (Reichswirtschaftsministerium).

The Reich Ministry of Economics supervises two

subordinate national agencies of importance to health service.

(1) The Reich Statistical Office (Statistisches Reichsamt) assembles, evaluates, and publishes statistical information on all fields of health service, including social insurance. The most important annual publications are one containing a vast array of bio-statistical data for the Reich -- Die Bewegung der Bevölkerung, Die Ursachen der Sterbefälle -- and one reporting on the operation of the sickness insurance programs set up under social insurance -- Die Krankenversicherung.

(2) The Reich Supervisory Office of Private Insurance (Reichsaufsichtsamt für Privatversicherung) is in charge of supervising commercial companies as well as non-profit voluntary associations active in the field of sickness insurance. (See SICKNESS INSURANCE, VOLUNTARY.)

REICH AND PRUSSIAN MINISTRY OF THE INTERIOR (Reichs- und Preussisches Ministerium des Innern).

The Reich Ministry of the Interior, which is in charge of all matters of general administration throughout the Reich, has a Division of Health Service, designated

as Abteilung IV. The Division exercises considerable powers through policy making and supervision in 27 fields of health activity officially listed as follows: (1) execution of the law concerning unification of health administration; (2) racial hygiene, population policy, and related subjects; (3) the professional education of physicians, dentists, veterinarians, pharmacists, and food chemists; (4) the training of midwives, laboratory assistants, nurses, and related groups; (5) medical ethics and similar problems; (6) all matters pertaining to state health officers; (7) general policy for preventive health services; (8) school health service; (9) prevention of tuberculosis; (10) organized care of the sick; (11) crippled children's programs; (12) medical service for the blind and deaf-mute; (13) general hygiene; (14) control of communicable diseases, including supervision of public health laboratories and institutes of hygiene maintained at the state level; (15) production and distribution of sera, vaccines etc.; (16) execution of the small pox vaccination law; (17) laws pertaining to foods; (18) the drug trade; (19) hospital policy; (20) swimming pools and other bathing facilities; (21) matters pertaining to Red Cross activities; (22) care of the mentally sick and defective; (23) disposal of the dead; (24) physical education; (25) health education; (26) medical research; and

(27) genealogical research.

Eight institutions are subordinated to the Division of Health Service. The most important ones are the Reich Health Office (Reichsgesundheitsamt), the Advisory Committee on Population and Race Policy (Sachverständigenbeirat für Bevölkerungs- und Rassenpolitik), and the Reich Advisory Council on Public Health (Reichsausschuss für Volksgesundheitsdienst). (For details see REICH HEALTH OFFICE, RACIAL HYGIENE, and REICH ADVISORY COUNCIL ON PUBLIC HEALTH.)

A series of publications on public health, the Handbücherei für den öffentlichen Gesundheitsdienst, is edited by members of the Division of Health Service.

REICH AND PRUSSIAN MINISTRY OF LABOR (Reichs- und Preussisches Arbeitsministerium).

The Reich Ministry of Labor is the highest authority in four fields of activity directly related to health service: (1) social insurance (Sozialversicherung); (2) the relationship between physicians in private practice and social insurance; (3) medical care for war veterans (ärztliches Versorgungswesen); and (4) industrial hygiene (Gewerbehygiene), including general supervision

of the state industrial physicians (staatliche Gewerbeärzte).

Subordinate offices in charge of social insurance matters are (1) the Central Insurance Office (Reichsversicherungsamt); (2) the agency administering pension insurance for salaried employees (Reichsversicherungsanstalt für Angestellte); and (3) the administrative agency in charge of miners' insurance (Reichsknappschaft).

Professional organizations affiliated with the Reich Ministry of Labor are (1) the German Association of Sickness Insurance Physicians (Kassenärztliche Vereinigung Deutschlands); (2) the German Association of Sickness Insurance Dentists (Kassenzahnärztliche Vereinigung Deutschlands); and (3) the German Association of Dental Technicians in Sickness Insurance Practice (Kassendentistische Vereinigung Deutschlands).

Among the periodicals sponsored by the Ministry are the Reichsarbeitsblatt, which carries texts of statutes and administrative decisions as well as signed articles on the fields assigned to the Ministry, and Arbeit und Gesundheit, which concentrates on problems of occupational hygiene.

RELAPSING FEVER (Rückfallfieber).

Relapsing fever is reportable throughout the Reich. This disease has been practically unknown in Germany since the end of the 19th century except for some outbreaks during the First World War. It may have reappeared sporadically in recent years as a result of wide-spread louse infestation (Verlausung).

Statutes concerning the control of communicable diseases require delousing (Entlausung) of the sick, of suspected cases, of their clothing, linen, beds, etc., and of their dwellings.

REPORTABLE DISEASES (Anzeigepflichtige Krankheiten).

Four basically different types of disease and conditions are reportable throughout the Reich: (1) communicable diseases (Übertragbare Krankheiten) as shown below; (2) occupational diseases (Berufskrankheiten), as described under OCCUPATIONAL DISEASES; (3) crippling conditions (for details see CRIPPLED CHILDREN'S PROGRAM); and (4) abortions (Abtreibungen), as described under MATERNAL HEALTH SERVICE.

Reportable Communicable Diseases
(In alphabetical order)

Type of disease (Krankheit)	Reporting required for			
	'Case of sickness (Er- krankung)	'Suspected case (Verdachts- fall)	'Carrier (Keim- träger)	'Death (Todes- fall)
Anthrax (<u>Milz-</u> <u>brand</u>)				
Bang's Disease (<u>Bangsche</u> <u>Krankheit</u>)	x		x	
Cholera (<u>Cholera</u>)	x		x	
Diphtheria (<u>Diphtherie</u>)	x			
Dysentery (<u>Über-</u> <u>tragbare Ruhr</u>)	x		x	
Encephalitis, epidemic (<u>Über-</u> <u>tragbare Gehirn-</u> <u>entzündung</u>)	x			
Food poisoning, bacterial (<u>bakterielle</u> <u>Lebensmittel-</u> <u>vergiftung</u>)			x	
Glanders (<u>Rotz</u>)	x		x	x
Leprosy (<u>Aussatz</u>)	x		x	
Malaria (<u>Malaria</u>)	x			
Meningitis, cerebro-spinal (<u>Übertragbare</u> <u>Genickstarre</u>)	x			x
Paratyphoid fever (<u>Paratyphus</u>)	x		x	x
Plague (<u>Pest</u>)	x		x	
Poliomyelitis (<u>Übertragbare</u> <u>Kinderlähmung</u>)	x		x	
Psittacosis (<u>Papageien-</u> <u>krankheit</u>)	x		x	x

Reportable Communicable Diseases (continued)

Puerperal fever (Kindbett- fieber)	x	x	x	x	x
Rabies, Including bites by rabies- suspected dogs (Tollwut- und <u>Bissverletzungen</u>)	x	x	x	x	x
Relapsing fever (Rückfallfieber)	x	x	x	x	x
Scarlet Fever (Scharlach)	x	x	x	x	x
Smallpox (Pocken)	x	x	x	x	x
Trachoma (Körner- krankheit)	x	x	x	x	x
Trichinosis (Trichinose)	x	x	x	x	x
Tuberculosis (Tuber- kulose) infectious pulmonary TB	x	x	x	x	x
Other forms (includ- ing skin TB)	x	x	x	x	x
Tularemia (Tularämie)	x	x	x	x	x
Typhoid (Typhus)	x	x	x	x	x
Typhus (Fleckfieber)	x	x	x	x	x
Venereal diseases (Geschlechts- krankheiten)			conditionally (see VENEREAL DISEASE CONTROL)		
Weil's disease (Weilsche Krankheit) or Infectious Jaundice (an- steckende Gelbsucht)	x	x	x	x	x
Whooping cough (Keuch- husten)	x	x	x	x	x
Yellow fever (Gelb- fieber)	x	x	x	x	x

It will be seen from this table that some of the communicable diseases which are known to be very common

in Germany are not reportable. They are chickenpox (Windpocken), German measles (Röteln), influenza (Grippe), measles (Masern), mumps (Ziegenpeter) and septic sore throat (Eitrig Halsentzündung). Also excluded from reporting is pneumonia (Lungenentzündung).

RICKETS (Rachitis).

Until a few decades ago rickets was very common. This disease was responsible for a large number of crippling conditions (Verkrüppelungen). It caused most of the cases of pelvi angusta (Beckenenge) with its resultant complications in childbirth.

During the last two decades, the frequency of rickets has declined markedly as a result of methodical application of prophylactic measures, such as the distribution of vitamins through infant health clinics and the provision of radiation by ultra-violet lamps (Bestrahlung mit künstlicher Hühnersonne) in public clinics of various types. In 1943, some large cities reported that three-fourths of all infants were found to be free of rickets.

Deterioration of the food situation in Germany coupled with shortages in vitamins may result in a noticeable increase in the frequency and severity of rickets. (See also NUTRITIONAL STATUS.)

SCARLET FEVER (Scharlach).

Scarlet fever is reportable throughout the Reich. The disease was very common before the war, occupying either first or second place on the list of all reportable communicable diseases. It must be noted, however, that several diseases distinguished by great frequency are not notifiable. (For details see REPORTABLE DISEASES.) During the war, the incidence of scarlet fever has multiplied. Reported cases numbered 70,650 in 1930; 112,509 in 1935; 159,597 in 1940; 279,117 in 1941; and 401,807 in 1942. The case rate per 100,000 population was 110 in 1930; 168 in 1935; 177 in 1940; 310 in 1941; and 446 in 1942. The vast majority of all cases occurred among children under 15 years of age. Areas with particularly high incidence of scarlet fever in recent years include Anhalt, Saxony, Hamburg, Bremen, Lippe and the Sudetenland. Mass evacuation of children from cities has probably exercised a marked effect on the regional distribution of the disease.

Deaths from scarlet fever numbered 771 in 1930; 995 in 1935; 1,700 in 1940; 3,233 in 1941; and 4,454 in 1942. The corresponding rates per 100,000 population can be estimated at 1.2; 1.5; 1.9; 3.6; and 5.0. In

the early 1940's the death rate from scarlet fever in Germany was 10 to 15 times as high as in the United States. The case fatality, however, has not changed to any significant extent. In the period from 1930 to 1942, it has been in the neighborhood of 1 percent.

The general principles of control are discussed under COMMUNICABLE DISEASE CONTROL. Specific measures include (1) active immunization (Schutzimpfung) by scarlet fever toxoid, which, however, is applied infrequently, and (2) regulations concerning the prevention of scarlet fever in schools and similar institutions. Teachers and pupils who are sick or who live in households with a case of scarlet fever are excluded from school. Readmission of persons who have been sick is allowed after 6 weeks at the earliest. The closing of schools is left to the discretion of the health officer (Amtsarzt).

SCHOOL DENTAL PROGRAM (Schulzahnpflege).

In a considerable number of communities the organized dental care of school children, called planmässige Zahnpflege, is an integral part of public preventive health services.

Objectives of the school dental program are (1) early detection of defective teeth (Früherfassung anbrüchiger Zähne), and (2) correction of dental defects discovered (Beseitigung von Zahnschäden).

To attain these objectives, all school children in certain grades are required to have mouth inspections made, and to undergo such treatment as is deemed necessary, a method called systematische schulzahnärztliche Sanierung. The service is given free or at nominal charges. Many of the cities operating such programs maintain school dental clinics (Schulzahnkliniken), which are staffed with part-time or full-time school dentists (Schulzahnärzte), one full-time dentist serving 4,000 to 5,000 children. In a number of smaller communities and in some rural areas, mobile clinics are used for this purpose. The school dental clinics are also available for emergency treatment between the intervals set for the Sanierung, and for special services such as treatment prior to admission for a child entering an institution in a health resort. In some sections of the country, only mouth examinations are provided through public clinics, while treatment service is rendered by dentists in private practice, and in some instances the whole program is organized on the

basis of service by dentists in private practice. In Prussia, 160 school dental clinics with 150 full-time and 655 part-time dentists were in operation in 1930. Most of them were tax-supported, and a few were maintained by sickness insurance organizations (Krankenkassen). More inclusive and more recent figures are lacking.

In 1943, the Nazi regime began to extend the principle of Sanierung. In that year all youths born in 1927, and in 1944 all youths born in 1928 and 1929 were ordered to have their teeth examined and treated. The sickness insurance organizations (Krankenkassen) were required to pay for the care of children whose families were eligible for social insurance, with the central insurance office (Reichsversicherungsamt) subsidizing the scheme. Cities and counties were charged with responsibility for payment in the case of children of non-insured families earning less than about 5,000 RM. annually. The health department was made responsible for enforcing the participation of all children called up. (See also DENTAL CARE.)

SCHOOL HEALTH SERVICE (Schulgesundheitspflege).

The school health service is regarded as the

cornerstone of the German system of preventive health work. In 1897, the city of Wiesbaden pioneered in the field. In 1904, the city of Mannheim appointed the first full-time school physician (Schularzt). In 1907, the city of Halle a. S. introduced full-time medical service at colleges, as well as at elementary, secondary and special schools, and the city of Stuttgart appointed the first full-time school nurse (Schulschwester). Since 1910 school health service under public auspices has developed rapidly throughout the Reich. In Prussia, in 1930, four-fifths of all children attending elementary and secondary schools, two-thirds of those going to colleges and institutions of higher learning, and half of those attending vocational schools were reached by organized school health services maintained by cities and counties. In South Germany, particularly in Baden and Würtemberg, this type of preventive health work has probably been developed more extensively than in Prussia.

Before the war the majority of school physicians served on a part-time basis. However, the number of full-time school physicians had been increasing steadily. In communities with well-developed school health service, one full-time doctor had charge of 5,000 to 6,000 school

children. Nurse-social workers, called Schulfürsorgerinnen, were assigned to the school health service at the ratio of one for every 2,500 to 3,000 pupils.

The principles followed in the organization of school health service are uniform. All children attending school are medically examined at least three times during the first eight years, and in some communities every other year. These Reihenuntersuchungen are complemented by regular "consultation sessions" (schulärztliche Sprechstunden). There, parents and teachers are advised on the handling of "problem cases", children found in need of supervision are given more detailed examination and guidance, and children with minor injuries or disorders receive emergency treatment. The findings made by the school physician and the school nurse, their recommendations and the results obtained are recorded on a card called Schulgesundheitsschein.

The functions to be performed by the personnel of the school health service include the following:

- (1) supervision of the sanitary conditions of the school building (Schulgebäude), including regular inspections (Besichtigungen); (2) participation in determining the curriculum and the arrangement of classes, rest periods (Pausen), etc.; (3) health supervision and health guidance of all school children; (4) consultant service to teachers and parents, as well as to public and voluntary health

and welfare agencies; (5) control of communicable diseases among school children and teachers, carried out in cooperation with the health officer (Amtsarzt); (6) revaccination against smallpox (Pockenwiederimpfung) and immunization, primarily against diphtheria (Diphtherieschutzimpfung); (7) selection of children, who for medical reasons, need school breakfast or school lunch (Schulspeisung); (8) certification as to exemption (Befreiung) of the child from participation in the mandatory physical training program (Leibesübungen); (9) selection of children for admission to convalescent homes, camps and similar facilities used for "rest cures" (Erholungsfürsorge), and for treatment in hospital-like facilities in spas and health resorts (Kurfürsorge); (10) examination of children for transfer to special classes (Sonderklassen) or schools (Sonderschulen), such as facilities for children who are hard of hearing (die Hörschwachen), have defective vision (die Sehschwachen), have speech defects (die Sprachgestörten), or are mentally backward (die Hilfsschulkinder); (11) arrangement for treatment of diseases and defects through available resources, in particular social insurance; and (12) participation in vocational guidance (Berufsberatung).

Organization and general supervision of the school health service are functions of the health department (Gesundheitsamt).

In normal times 6 to 10 percent of the children coming of school age were found not yet fit to enter school (noch nicht schulreif), 20 to 25 percent needed regular health supervision (waren Überwachungsbedürftig), and 15 to 20 percent of those leaving school were not yet completely physically fit for work (noch nicht voll berufsreif). It is fair to assume that with the deterioration of economic conditions, a much larger proportion of school children will be found in need of special care.

SEWAGE DISPOSAL (Abwasserbeseitigung).

Disposal of human wastes and liquid wastes from households is based on either of two methods of collection or both in combination: (1) the water-carriage sewerage system (Kanalisation), and (2) the use of pails, basins, cesspools, septic tanks or similar devices (Gruben- und Tonnensystem).

The water-carriage sewerage system may be a combined system (Mischsystem) -- receiving feces, household sewage, and rain water in the same canal -- or it

may be a separate system (Trennsystem), with feces and household sewage going into one and rain water into another canal. Both systems may be found in a given community. A number of cities collect industrial waste water along with domestic sewage, without always providing for treatment of the industrial wastes.

Before the war, about four-fifths of the people living in cities of more than 5,000 population and a certain proportion of the rural population were served by modern water-carriage sewerage systems and had water closets in their apartments or homes. It must be borne in mind, however, that nearly one-half of the population lived in communities with less than 5,000 inhabitants. Pit privies and tight-vault privies are common in rural areas and are also used to a considerable extent in cities -- primarily in slum areas. Unscreened outhouses are not uncommon. The pails (Tonnen) or basins (Gruben) are emptied at regular intervals.

For sewage treatment (Reinigung), a variety of methods is employed, either individually or in combination. They include mechanical clarification (Ab-siebungsanlagen) by installations such as racks, screens or grit chambers; sedimentation in settling tanks or basins (Absetzanlagen); chemical treatment (chemische

Klärvfahren); biological treatment (biologische Verfahren) by a large variety of processes, including various types of anaerobic digestion, filtration and aeration; irrigation on sewage farms (Rieselfelder), or the use of fish ponds (Fischteichverfahren); disinfection; and others. Of treatment plants in cities with more than 5,000 population, the majority had settling tanks only, while a considerable proportion used complete biological treatment, trickling filters, or irrigation fields. In a number of communities, sewage flows into Haus-kläranlagen prior to further disposal. In many places, either the raw sewage or the effluent from the treatment plant is pumped some distance to areas set aside for irrigation. In other places treated sewage is discharged into streams and lakes. In many rural areas night-soil is used for fertilizing purposes, or buried, if not discharged into rivers without treatment. The utilization of sewage for agricultural purposes has been emphasized by the Nazi regime.

The establishment and maintenance of all provisions needed for proper sewage disposal is a public function, normally carried out by municipalities and counties. Where there is no water-carriage system, the local authority is

responsible for the collection and disposal of human wastes and liquid wastes from households. Sewage disposal is regulated by law, and its hygienic aspects are supervised by the health officer (Amtsarzt). Explicit rules determine the handling of industrial wastes -- a problem of growing importance as a result of expansion of industry. In industrial areas along rivers, municipalities and industrial corporations long ago formed associations (Verbände) to prevent the pollution of stream waters and to relieve industrial establishments of the necessity of disposing of wastes individually. The law of 10 February 1937 concerning water and land associations (Gesetz über Wasser- und Bodenverbände) aimed at the generalization and standardization of such associations.

SICKNESS INSURANCE, COMPULSORY (Zwangskrankenversicherung).

Legal requirement of insurance against sickness (Versicherungspflicht) applies to (1) wage earners in industry, commerce, agriculture, domestic service, and service trades, regardless of income; (2) specified groups of salaried employees, including professional people, merchant seamen, and the crews manning the inland water fleet, if their regular annual earnings (regelmässiger

Arbeitsverdienst an Entgelt) do not exceed 3,600 RM. and (3) specified groups of self-employed persons, such as teachers and musicians, with earnings less than 3,600 RM. annually.

Family dependents (Familienangehörige) of the insured are covered automatically, although they do not qualify for the full service nor for most of the cash benefits available to the insured. A considerable number of groups are assigned to the sickness insurance system, obtaining necessary medical care through its machinery. Among these groups are (1) recipients of unemployment compensation (Arbeitslosenunterstützung) and related types of benefits; (2) war veterans (Kriegsbeschädigte); (3) civilians injured by enemy action; (4) survivors (Hinterbliebene) of war veterans and of civilians killed as a result of enemy action; and (5) recipients of pensions (Rentenempfänger) from any of the pension insurance schemes.

Voluntary membership (Versicherungsberechtigung) in the program is open to (1) persons who wish to continue insurance after becoming ineligible for the compulsory program and (2) persons who have never been subject to

required insurance. In such cases, the annual income of the person in question must not exceed 8,400 RM.

The exact number of persons covered by sickness insurance is unknown. It is certain, however, that before the war more than 23,400,000 persons were listed as insured, and that a majority of the German people -- probably two-thirds -- received service through this program. Three-quarters of all women in childbirth were provided with maternity service under the system.

The hazards covered by the program are sickness, maternity, temporary disability due to these causes, and death of the insured breadwinner. On the basis of agreements with the administration of accident insurance (Unfallversicherung), insured persons contracting an occupational injury or disease receive certain services through the sickness insurance organization.

The benefits (Leistungen) of sickness insurance are of two basic types: services and cash. In either case, statutory benefits (Regelleistungen), i.e. standard benefits required by law, are distinguished from optional benefits (Mehrleistungen), i.e., such additional benefits as the individual administration may want to grant within the limits set by law.

The major services of the sickness insurance program are: (1) services by physicians, specialists as well as general practitioners; (2) services by dentists; (3) services by dental technicians; (4) services by midwives; (5) services by nurses, including visiting nurses and housekeeping aides; (6) care in general and special hospitals, including convalescent homes; (7) drugs; (8) minor medical and surgical appliances; and (9) special treatment, such as physical therapy. The extent to which these services are available varies somewhat.

In general, the insured is entitled to more service and for a longer period of time than the family dependents, although such differentiation is not maintained in regard to maternity service. For the sick, medical care is available from the first day on which it is requested. In case of maternity, a qualifying period must be completed. It amounts to a total of 10 months of membership during the two years preceding delivery, including 6 months immediately prior to confinement.

The most important types of cash benefit are (1) disability compensation (Krankengeld), paid to the insured from the fourth day of inability to work

(Arbeitsunfähigkeit) up to a maximum period that varies according to special conditions; (2) a maternity allowance (Wochengeld), available to both insured women and the family dependents of insured persons for a total period of 12 weeks prior to and after delivery; (3) a nursing allowance (Stillgeld) for nursing women, both the insured and family dependents; and (4) funeral allowance (Sterbegeld), paid to survivors of insured persons.

The present organization of professional and related services and of care in hospitals and institutions rests largely on broad principles adopted prior to the Nazi regime. Except for the introduction of political and racial doctrines into the scheme, and the abolition of group clinics (Ambulatorien) maintained by a number of sickness insurance organizations, the Nazi regime has preserved, and in some respects extended, former practices.

The relationship between the medical and dental professions on the one hand and the sickness insurance organizations on the other is regulated by law. It rests on the principle of collective bargaining (Mantelverträge and Gesamtverträge) between national associations representing the respective parties. Special professional bodies -- the German Association of Sickness Insurance Physicians (Kassenärztliche Vereinigung

Deutschlands), the German Association of Sickness Insurance Dentists (Kassenzahnärztliche Vereinigung Deutschlands), and the German Association of Dental Technicians in Sickness Insurance (Kassendentistische Vereinigung Deutschlands) -- are responsible for formulating the broad policies and general procedures to be followed in organizing professional services, for the provision of sufficient professional personnel, for supervision of those engaged in insurance practice, and for disbursement of the payments to the professional persons. Membership in these associations is mandatory for every physician, dentist, and dental technician serving under the program.

Professional services under sickness insurance are organized on the principles of individual practice by private practitioners and free choice. Every physician, dentist, and dental technician meeting specified requirements is eligible to participate in the service if he so desires, provided he has his name entered on an official list and complies with the rules laid down by the national associations. Persons eligible for sickness insurance service have free choice among local participating physicians, dentists, and dental technicians.

Designated higher authorities maintain registers of physicians (Arztregister), containing the names of all physicians available for insurance practice in their region. In addition, a nation-wide list (Reichsarztregister) is kept. Similar registers are maintained for dentists and dental technicians (Register für Zahnärzte und Dentisten).

As a general rule, one physician is admitted for every 600 insured persons (this means one physician for about 1,000 to 1,200 persons eligible for service), and specialists are not allowed to exceed 40 percent of all insurance physicians in a given locality. Admission is limited to practice in a certain geographical area. The general rules for the admission of dental practitioners to insurance practice call for 6 dentists and 4 dental technicians, a total of 10, for every 15,000 insured persons. Before the war, the large majority of all physicians, dentists, and dental technicians in private practice served as insurance doctors (Kassenärzte), insurance dentists (Kassenzahnärzte), and insurance dental technicians (Kassendentisten). These persons derived the greater part of their incomes from payments by sickness insurance organizations. The administrative agencies

of sickness insurance transfer to the association of insurance physicians (Kassenärztliche Vereinigung) a definite amount of money (Gesamtvergütung), which is based on a per capita rate set by the administration and multiplied by the average number of persons eligible for service. The professional association pays the participating physicians according to its own schedule, in many instances on the basis of the unit system (Punktsystem).

Hospital care is given by all institutional facilities approved for insurance service. Professional service to hospitalized patients is furnished mostly by closed staffs, and in a relatively small number of instances by open staffs consisting of doctors with hospital privileges.

Supervision of professional services is a function of the medical administrators (Vertrauensärzte) attached to special divisions in the regional Landesversicherungsanstalten. According to the statutes, one full-time Vertrauensarzt is to be appointed for every 25,000 insured persons. This rule, however, had not been applied generally before the war. In 1937, there were 412 full-time and 499 part-time Vertrauensärzte. The duties of the Vertrauensärzte include (1) professional advice

and assistance to the sickness insurance organizations; (2) general supervision of the professional services rendered; (3) general supervision of disability certification; and (4) consultant service in regard to hospitalization, sanatorium treatment, and similar more costly services.

Responsibility for the direct administration of compulsory sickness insurance is vested in special statutory bodies, called Krankenkassen, rather than in the public agencies administering health service for the general public. The Reich Insurance Code (Reichversicherungsordnung) recognizes four standard types of Krankenkassen: (1) the Ortskrankenkassen in cities; (2) the Landkrankenkassen in rural areas; (3) the Betriebskrankenkassen in industrial and commercial establishments with at least 150 employees and in public administrations; and (4) the Innungskrankenkassen for persons employed by members of a handicraft guild. In addition, there are a special organization for seamen the Seekrankenkasse, and a number of organizations used primarily by white collar workers, the Ersatzkrankenkassen. Sickness insurance for miners is administered by special bodies, the Bezirksknapp-schaften, which are regional agencies of the Reichsknapp-

schaft. In actual practice, not only various types of Krankenkassen but also several Krankenkassen of the same type may operate in one community, and the variety as well as the number of Krankenkassen increases with the size of the community. Although the total number of administrative bodies has been reduced steadily since about 1910, it still exceeded 4,400 before the war. The Betriebskrankenkassen led by far in number. The Orts-krankenkassen had more than half of all the insured.

Supervision of the Krankenkassen and the settlement of disputes are functions of special authorities, the Versicherungsbehörden. At the local level there are insurance offices (Versicherungsämter), at the intermediate level higher insurance offices (Oberversicherungsämter), and at the national level the Reich Insurance Office (Reichsversicherungsaamt). The last is the highest supervisory agency, and the supreme court of appeal. At the ministerial level the Reich Ministry of Labor (Reichsarbeitsministerium) is responsible for social insurance.

The operation of the sickness insurance program is financed mainly by contributions of both the employees and the employers. Voluntary members pay their own contributions. The cost of service for assigned groups

is born by the agencies responsible for the respective individuals, i.e., by public agencies for the unemployed, by the Reich for veterans, by the pension insurance system for pensioners, etc. The total annual expenditures of all sickness insurance organizations amounted to approximately 2,000,000,000 RM. shortly before the war. Of this sum, nearly two-thirds was expended on services and benefits in kind, approximately one-fourth on cash benefits, and less than one-tenth on administration.

As the figures on coverage and expenditures show, the sickness insurance system occupies a dominant position in the German health service. The continuation of this program, de-Nazified and adjusted to the emergency situation, is fundamental to the maintenance of emergency health service. (See also ACCIDENT INSURANCE, MINERS' INSURANCE, PENSION INSURANCE, and SOCIAL INSURANCE.)

SICKNESS INSURANCE, VOLUNTARY (Private Krankenversicherung).

A large number of people are voluntarily insured against sickness. In 1938, 9,400,000 persons belonged to a variety of non-profit associations, or carried policies with commercial companies providing for protection in case of sickness and death. By far the largest enroll-

ment was in mutual associations (Versicherungsvereine auf Gegenseitigkeit). The annual premium income of all organizations officially classified as private Krankenversicherung was close to 400,000,000 RM. During the war the number of persons covered by voluntary sickness insurance has probably increased.

All non-profit organizations and commercial firms active in the field of sickness insurance are supervised by the Reich Supervisory Office of Private Insurance (Reichsaufsichtsamt für Privatversicherung), which is subordinate to the Reich Ministry of Economics (Reichswirtschaftsministerium).

Since any program based on the insurance principle rises and falls with the ability of people to make the regular payments, the fate of the German private Krankenversicherung is inextricably bound up with the economic conditions that will prevail in Germany in the post-hostility and post-war periods.

SMALLPOX (Pocken, Blattern).

Smallpox is reportable throughout the Reich. Except for a short period during and immediately after the war of 1914-1918, the disease has been so rare that

most physicians have never seen a case and would experience difficulty in diagnosing it. Sporadic cases have been introduced primarily by migrant workers. In 1930 two cases and in 1935 one case were reported. As far as is known, smallpox has remained extremely rare during the war, as a result of the enforcement of smallpox vaccination in Germany proper and in the incorporated territories. (See SMALLPOX VACCINATION.)

The experience of the First World War indicates that the possibility of an introduction of smallpox cannot be entirely dismissed. At that time the disease occurred primarily among old people and inevitably among those -- relatively few -- persons who had never been vaccinated.

SMALLPOX VACCINATION (Pockenschutzimpfung).

Compulsory smallpox vaccination has been carried out systematically since the adoption of the Reich vaccination law of 1874 (Reichsimpfgesetz). The procedures have been regulated to the minutest detail by a series of decrees. All pertinent statutes were recodified in 1940.

The manufacture of vaccine and its distribution to pharmacies and physicians are state monopolies

exercised by special institutions, the staatlichen Impfanstalten, of which there were 12 before the war. The law requires the first vaccination (Erstimpfung) of every child before completion of the first calendar year following the year of birth, and re-vaccination (Wiederimpfung) in the calendar year during which the twelfth year of life is completed. The police must check compliance with the requirement of vaccination (Impfpflicht). Evasion is a punishable offense. Only physicians are permitted to vaccinate, and they alone are responsible for deferring children.

To carry out the provisions of the law, the counties (Kreise) are required to establish administrative districts (Impfbezirke) and appoint designated physicians (Impfarzte). Emphasis is placed on the utilization of doctors employed in preventive clinics for infants (Sauglingsfùrsorgestellen) and of school physicians (Schularzte). The health officer (Amtsarzt) participates actively in vaccination, particularly in small communities.

Vaccination is free. Public vaccination clinics (Offentliche Impftermine) and follow-up clinics (Nachschaftermine) are held at certain periods of the year. Successful first vaccination is certified on a

red form, while a green form is used for revaccination.

The health department is charged with responsibility for supervision of all physicians appointed for vaccination and the checking of their records once every 3 years. In addition, it supervises the supply of vaccine and proper execution of the law. Finally, it must take steps against anti-vaccination groups which do exist, although their influence is insignificant.

The percentage of infants deferred for health reasons at the time they should be vaccinated has increased steadily. It amounted to approximately 10 percent in 1910 and 1920 and rose to about 16 percent in 1930 and 1935. Of the school children due for re-vaccination, 1.5 percent were deferred in 1910, 1.7 percent in 1920, 2.6 percent in 1930, and 4.3 percent in 1935. Definitely excluded from the first vaccination were only about 2 to 3 percent of the infants and small children and about 0.5 percent of the school children that came up for revaccination in the period of 1910 to 1935. These figures indicate that the resident population of Germany is fairly well protected against smallpox.

SOCIAL INSURANCE (Sozialversicherung).

An extensive system of compulsory insurance,

developed gradually since the 1880's, provides for protection against the following hazards: (1) sickness; (2) maternity; (3) temporary disability due to sickness or maternity; (4) accident, including temporary and permanent disability; (5) permanent disability due to sickness; (6) old age; and (7) death of the breadwinner due to sickness or accident. Legislation on social insurance, however, does not employ the functional approach consistently. The same type of provision is made for different socio-economic groups under different nation-wide laws. From the point of view of health service, the most important of these laws are (1) the Reich Insurance Code of 19 July 1911 (Reichsversicherungsordnung); (2) the Salaried Employees' Insurance Law of 20 December 1911 (Angestelltenversicherungsgesetz); and (3) the Miners' Insurance Law of 23 June 1923 (Reichsknappschaftsgesetz). All three have been amended frequently. By the Reich law of 5 July 1934 concerning the organization of social insurance (Gesetz über den Aufbau der Sozialversicherung), revision on a broader scale was initiated. As far as is known, the implementation of this law has been slow and incomplete. Details of health service under social insurance are given under the headings ACCIDENT INSURANCE,

MINERS' INSURANCE, PENSION INSURANCE, and SICKNESS INSURANCE. The following summary gives an over-all picture of social insurance.

The Reich Insurance Code (Reichsversicherungsordnung) contains numerous provisions for the protection of workers, certain groups of salaried employees, and family dependents of the insured. Sickness and maternity, and temporary disability and death from these causes are dealt with in part II of the Code under the title "Krankenversicherung". Accident and occupational diseases, and temporary disability and death from these causes are subjects treated in part III under the title "Unfallversicherung". Permanent disability, prolonged temporary disability, old age, and death of the breadwinner constitute the subject matter contained in part IV, "Invalidenversicherung".

The Salaried Employees' Insurance Act (Angestelltenversicherungsgesetz) applies to salaried employees and also to a number of self-employed persons. It provides for protection against the hazards of permanent disability, serious but temporary disability, old age, and death of the breadwinner.

The Miners' Insurance Act (Reichsknappschaftsgesetz) protects the workers, the great majority of

salaried employees, and the family dependents of persons employed in the mining industry and related enterprises. It covers all hazards except accident and occupational disease, which come under the Reich Insurance Code.

The legislation on social insurance is exceeded in complexity by the administrative organization of the program. The present situation reflects not only historical developments, but also the successful activity of pressure groups representing special interests.

Sickness insurance is administered by local statutory bodies called Krankenkassen. Supervisory and judicial functions, varying in scope, are vested in insurance offices (Versicherungsämter) at the local level, in higher insurance offices (Oberversicherungsämter) at the intermediate level, and in the Central Insurance Office (Reichsversicherungsamt) at the national level.

Accident insurance is administered by local statutory bodies, the Berufsgenossenschaften, although there are a few exceptions to this rule. These are supervised by the Central Insurance Office (Reichsversicherungsamt).

Pension insurance for workers is administered by regional statutory bodies, the Landesversicherungs-

anstalt, and these are supervised by the Central Insurance Office.

Pension insurance for salaried employees is administered centrally by the Reichsversicherungsanstalt für Angestellte which is under the supervision of the Central Insurance Office.

Miners' insurance is also administered centrally by the Reichsknappschaft, but this agency maintains 20 regional offices (Bezirksknappschaften) for routine functions. Supervisory powers are vested in the Central Insurance Office.

The only common feature of the administrative structure, then, is the Central Insurance Office -- the highest supervisory authority and the supreme court of appeal for all organizations administering social insurance. This agency, in turn, is subordinated to the Reich Ministry of Labor (Reichsarbeitsministerium).

Up to the advent of the Nazi regime, the internal organization of all bodies administering social insurance was based on the principle of self-government, with more or less complete representation of all groups on committees or councils. This form of organization was abolished by the Nazis, and replaced by one based on the leader-

ship principle.

The main source of revenue for all social insurance programs except accident insurance has been, and still is, the income from contributions (Beiträge) payable by both employers and employees. Accident insurance is financed by employers only. Tax funds have been used to a relatively small extent in sickness insurance, but to a considerable extent for the purpose of subsidizing miners' insurance and pension insurance. Before the war, the total annual expenses of all social insurance organizations exceeded 4,200,000,000 RM., and more than 3,800,000,000 RM. were spent on services and benefits.

The future of social insurance will depend largely on the extent of unemployment, and the possibility of balancing sharply reduced income from contributions with expenses for a curtailed social insurance program. In normal times the agencies administering social insurance were required to maintain substantial reserves for contingencies. It is highly doubtful that any reserve funds worth mentioning are still available.

STATISTICAL SOURCE MATERIAL (Statistisches Quellenmaterial).

The most important publications containing statistical data on health conditions and health services in Germany are (1) the periodical Reichsgesundheitsblatt, issued by the Reich Health Office (Reichsgesundheitsamt); (2) the Statistisches Jahrbuch für das Deutsche Reich, published annually by the Statistisches Reichsamt, with sections on Bewegung der Bevölkerung, Versicherungswesen, and Gesundheitspflege, and an appendix containing international figures; and (3) the series (a) Die Bewegung der Bevölkerung. Die Ursachen der Sterbefälle and (b) Die Krankenversicherung, both published annually by the Statistisches Reichsamt.

Up to the middle of the 1930's, statistical data were rather inclusive and very accurate. Since that time they have steadily deteriorated in completeness, accuracy, and comparability. Computation of rates has become nearly impossible, because of population changes directly or indirectly related to the war. With the annexation of new territories, the reporting areas have increased greatly. Millions of people have been shifted from the Old Reich to annexed territories, from occupied areas to

the Old Reich, and from one section of the Old Reich to another. Some ten million foreign workers have been added to the population. Thus, the significance of many statistical data, in particular those on the incidence of diseases, has become hard to assess. This difficulty is certain to increase with demobilization, the return of war workers to their normal residences and of evacuated persons to their home towns, repatriation of foreign workers and war prisoners, and the transfer of populations from ceded areas.

TRACHOMA (Körnerkrankheit).

Trachoma is reportable throughout the Reich. As a result of the systematic application of control measures, this disease was uncommon before the war. In 1930, 1407 cases were reported in the Reich, and from then until 1939 the annual figures remained in the hundreds. Most of the cases occurred in a few eastern areas of the country. Since 1940 the frequency of trachoma has increased greatly. In the territory of the old Reich 2,979 cases were reported in 1940 and 2,770 in 1941. Including the incorporated territories, the figures were 5,586 in 1940; 9,196 in 1941; and 8,564 in 1942. The official data, however, are understatements, as they cover only such cases as have come to the attention of physicians. Systematic examination of school children in infected areas would provide a much better picture of the extent of the infection.

As a result of the shifting of populations, the large-scale importation of labor from infected countries, and uncleanliness during the war, trachoma probably has spread to areas formerly not at all affected. Recently a number of cases have been reported from Southern Germany.

It has long been established policy to examine all school children in infected areas and to maintain free diagnostic and treatment service in communities where trachoma cases are numerous. Migrant workers coming from foreign countries are required to take an eye examination. Teachers and pupils with trachoma are excluded from school. They are readmitted after the disappearance of purulent discharge, but the children must be separated from others. Compulsory treatment is legally permissible, if necessary for effective control of the disease.

TRICHINOSIS (Trichinose).

As a result of strict enforcement of meat inspection as part of the system of hygienic control of food (see FOOD CONTROL), trichinosis was very rare before the war. Officially reported cases numbered 95 in 1930 and 12 in 1935. If allowance is made for incompleteness in reporting, the total number of trichinosis cases per year was probably far below one hundred prior to the war. There were 12 deaths from trichinosis in 1930, and none in 1935.

Since the beginning of the war the situation has

changed. According to the reports of veterinarians in official positions (beamte Tierärzte), 350 trichinosis cases and 35 deaths from this disease occurred in 1941. The increase is attributed to the incorporation of territory where meat inspection was not well developed. In 1942, reported cases of trichinosis declined to 85 and deaths to 8, indicating the effect of stricter meat inspection in eastern areas.

If the existing machinery for food inspection is put to work and black market sales are rigorously suppressed, trichinosis should not present a problem.

TUBERCULOSIS (Tuberkulose).

The following forms of tuberculosis are reportable throughout the Reich: infectious pulmonary and laryngeal tuberculosis (ansteckende Lungen- und Kehlkopftuberkulose); skin tuberculosis (Hauttuberkulose); and tuberculosis of other organs (Tuberkulose anderer Organe).

The number of reported new cases of infectious pulmonary and laryngeal tuberculosis in Greater Germany was 98,062 in 1940; 117,558 in 1941; and approximately 127,000 in 1942 and 1943. The corresponding rates were 109, 131, and 141 per 100,000 population. Reported cases of extra-

pulmonary tuberculosis increased from 11,446 in 1940 to about 18,200 in 1943, or from about 13 per 100,000 population to about 21. The figures for the last years may well be understatements. A continued rise in the incidence of all forms of tuberculosis in the near future must be anticipated in view of inadequate food, over-crowding, unhygienic conditions of work, growing deficiencies in the machinery of health protection, and lack of proper medical care during the war years.

On the basis of systematic x-ray examinations (Röntgenuntersuchungen) in a number of localities, it is estimated that there are at least 200 to 250 infectious cases of pulmonary tuberculosis per 100,000 population. Here again it is questionable whether this estimate comes near the truth.

In contrast to the morbidity statistics, which were unified in the 1930's only, nation-wide mortality statistics date back to the 1870's. Since then the curve of tuberculosis mortality has been declining, except for a short period of time. In the 3-year period preceding the First World War, the number of tuberculosis deaths averaged 146 per 100,000 persons. During the First World War the tuberculosis death rate rose sharply and, in 1918,

was nearly twice as high as in 1913, an event generally attributed to the "hunger blockade" (Hungerblockade). Since the early 1920's, the curve has dropped rapidly and continuously. In 1930 there were 79 tuberculosis deaths (all forms) per 100,000 population, and in 1935 the figure was approximately 63. Thus the rates were higher than in the United States (71 in 1930 and 55 in 1935) but lower than in England (90 in 1930 and 72 in 1935). Since the end of the 1930's the tuberculosis death rate has shown a rising tendency. To judge from the meager information available, the number of deaths from tuberculosis (all forms) per 100,000 population exceeded 70 in 1942. It is certain to have increased considerably since that time. In 1943, it was officially stated that the rate in large cities had risen to more than 80.

The curve of the distribution of deaths by age groups has the form of a V. Infants and old people are the groups with high mortality. The frequency of deaths is very low in the preschool and school ages, goes up in the ages between 18 and 20, and rises continuously in the productive age groups. In recent years, the death rate of women between 20 and 30 years of age showed a comparatively marked increase. In general, cities have a lower death

rate than rural areas, as they possess a more highly developed system of control which counterbalances the harmful effects of urbanization and industrialization. In Germany, as in other countries, low income and high tuberculosis mortality are correlated. In some sections of the country, however, certain social groups belonging to the economic middle class have been afflicted by tuberculosis much more than others who are eligible either for social insurance or public assistance. This has been observed particularly in Baden and Hessen-Nassau.

The primary source of infection has been, and is, man. Bovine tuberculosis has been of secondary importance in the past, but has become more important in recent years as a result of increased consumption of milk from tuberculous cows (perlsüchtige Kühe).

TUBERCULOSIS CONTROL (Bekämpfung der Tuberkulose).

The general objectives of tuberculosis control in Germany are officially stated as (1) detection and elimination of sources of infection (Erfassung und Sanierung der Infektionsquellen); (2) improvement of the resistance of infected persons (Stärkung der Abwehrkräfte der durch eine Infektion Gefährdeten); and (3) improvement of the

resistance of persons exposed to infection (Stärkung der Abwehrkräfte der durch eine Infektionsgelegenheit Bedrohten).

The health department is legally vested with responsibility for the administrative organization and general supervision of all measures necessary for the effective control of tuberculosis. Its work is based on the reports of tuberculosis cases (see TUBERCULOSIS). The attending physician and the superintendent of institutions of any kind must report on notifiable cases, the diagnostic laboratories on positive sputa, and the patients themselves on any change of residence. Basic functions of the health department include (1) the organization of activities designed to prevent the spread of tuberculosis; (2) proper utilization of the available medical care facilities and professional services; and (3) health education (hygienische Belehrung) of the individual sick, the contacts, and the public at large.

The hub of the control program is the tuberculosis clinic (Tuberkulosefürsorgestelle). Clinics must be available in each district in a number adequate to meet local needs, and they must be staffed and equipped according to standards laid down in the statutes pertaining to the

unification of health administration (see HEALTH DEPARTMENT). Before the adoption of this law in 1934, there were already some 1,300 tuberculosis clinics in operation, but they were distributed unevenly. All were staffed with physicians, most of whom were either experienced in tuberculosis work or accredited as specialists (some 2,200), and with public health nurses (some 4,000). Their quality differed a good deal, and a substantial fraction did not possess x-ray laboratories of their own. The number of tuberculosis clinics has probably been somewhat increased during the 1930's, particularly in areas formerly served inadequately. Whether improvements in other respects have been achieved is open to doubt.

At present the health departments are legally responsible for the provision of tuberculosis clinics in their districts. However, other agencies have long maintained such institutions, in particular the organizations administering invalidity insurance (Invaliden-versicherung). Thus, in some localities the tuberculosis clinic may be a tax-supported institution, in others an institution operated by a social insurance organization, and in still others both types may be found side by side.

The major functions of the tuberculosis clinic are: (1) case-finding; (2) provision of diagnostic service -- including tuberculin-testing, routine clinical laboratory examination, and routine fluoroscopy (Durchleuchtung) supplemented by x-ray picture (Röntgenbild) when indicated; (3) arrangements for "prophylactic treatment" (vorbeugende Behandlung) in preventoria, homes in resort places, etc.; (4) arrangements for care in hospitals, sanatoria, and at the home of the patient; (5) provision of ambulatory treatment for patients with pneumothorax (Gasbrust), primarily refills (Nachfüllungen); (6) health supervision of the sick and contacts; (7) improvement of nutritional conditions by Ernährungsfürsorge or Nahrungsmittelbeihilfen and of housing conditions by Sanierung der Wohnung, including disinfection and isolation of the sick; (8) participation in vocational guidance and placement (Berufsberatung und Arbeitsvermittlung); (9) consultant service to other agencies such as welfare departments (Wohlfahrtsämter) and employment agencies (Arbeitsvermittlung), and to the preventive health service system, in particular the maternal and child health clinics and the school health service; and (10) health-education. Roentgenological examinations of groups, such as youths

or industrial workers, or of the greater part of the population are strongly emphasized. Recently they were carried out in a number of communities, for instance, in Stuttgart.

Teachers and pupils with infectious pulmonary tuberculosis are excluded from school and allowed to return only if a certificate of the health officer (Amtsarzt) or a designated medical officer states that danger of infection is absent. Candidates for teaching positions are required to present a health certificate, including an x-ray picture, before being appointed for a probationary period and again prior to their permanent employment. In addition, the higher school authorities are empowered to request such certificates whenever tuberculosis is suspected.

Biologic prophylaxis against tuberculosis is applied, but on a small scale. The Calmette method has fallen into disrepute after a disaster which, according to the best information available, was caused by negligence in handling cultures, rather than by the B.C.G. vaccine.

Institutional, ambulatory, and home care of patients with tuberculosis or of persons in need of preventive measures is provided by the organizations

administering social insurance, by public agencies, or by voluntary organizations, depending upon the socio-economic conditions of the patient.

Persons covered by social insurance are entitled to receive home, ambulatory, and hospital care from the various sickness insurance systems. (See SICKNESS INSURANCE and MINERS' INSURANCE.) They may obtain treatment in sanatoria (Heilstättenbehandlung) from the pension insurance system. (See PENSION INSURANCE.) Actually, the Landesversicherungsanstalten, Reichsversicherungsanstalt für Angestellte, and Reichsknapp-schaft have spent large sums on the treatment of active cases in sanatoria, (Heilverfahren or Verschickungen in Heilstätten) as well as on preventive health services and economic assistance (Heilmassnahmen und sonstige Fürsorge). Tuberculosis contracted in clinics, laboratories, hospitals, etc. is recognized as a compensable occupational disease.

Persons not eligible for social insurance are protected by the Reich law on aid to the tuberculous (Tuberkulosehilfe des Reichs) which became effective on 1 April 1943. This law applies to all persons who do not qualify for service by social insurance, and who

have annual incomes not exceeding 7,200 RM. if single and 8,400 RM. if married. For each child the limit is extended by 600 RM., e.g., a couple with three children is eligible if the annual income does not exceed 10,200 RM. In practice, this means that all but an insignificant fraction of the population has ready access to complete medical care and, in addition, may obtain needed financial assistance (wirtschaftliche Fürsorge). The services and benefits under this program are designed for the control of tuberculosis and are therefore not regarded as public assistance in the legal and administrative sense. Responsibility for the costs is placed on large administrative units, the Landesfürsorgeverbände, rather than on the localities.

In addition to the social insurance organizations and public agencies, a party organization, the Tuberkulosehilfswerk der N.S.V., has been active in the field of tuberculosis control.

To coordinate the tuberculosis activities of all public agencies and voluntary organizations, working associations (Arbeitsgemeinschaften) were widely, although not generally, developed under the Weimar Republic. Continuing and extending this policy, the Nazi Regime

charged the health officers (Amtsärzte) with the duty of establishing such associations in their districts (die der Tuberkulosebehandlung und Fürsorge sich widmenden Stellen ... sind zu einer praktischen Arbeitsgemeinschaft zusammenzufassen).

TUBERCULOSIS HOSPITALS AND RELATED FACILITIES (Tuberkulose-krankenhäuser und verwandte Einrichtungen).

Facilities for the treatment and care of patients with active tuberculosis are of four main types: (1) Small tuberculosis divisions are maintained in many general hospitals and, also, in certain special hospitals such as those for mental patients. All but the latter serve for the observation of doubtful cases, treatment of curable cases until they can be transferred to a sanatorium, and care of far advanced cases. (2) Sanatoria (Heilstätten) and tuberculosis hospitals (Tuberkulosekrankenhäuser) are operated by organizations administering pension insurance, by cities, by non-profit voluntary organizations, and by individuals, most of whom are physicians in private practice. They admit primarily those patients whose condition warrants an assumption that the disease can be arrested and earning capacity restored. (3) Colonies

(Siedlungen) for discharged patients exist in the neighborhood of some sanatoria. (4) Homes for advanced cases are maintained by a few cities (for example, Stettin, Dortmund, Nürnberg), and a number of chronic disease hospitals (Pflegeanstalten) are equipped with tuberculosis divisions for the prolonged segregation of patients in a chronic infectious stage.

In 1939, there were 27,336 beds for tuberculous adults in 208 units, and 5,765 beds for tuberculous children in 39 units. The total bed capacity was equal to 1 bed per annual death from tuberculosis, i.e., half of what experts consider adequate under normal conditions.

An entirely different type of facility is represented by the large number of camps, homes (Erholungsheime), and hospital-like institutions (Kuranstalten) at the seashore, in the mountains, or in the country. They are maintained mainly by social insurance organizations, cities and counties, and, to a not inconsiderable extent, by private organizations. They are extensively used for the purpose of improving the resistance of infected children or persons exposed to infection. Figures on the number and bed capacity of these institutions are lacking. Finally, a number of communities possess day camps

(Tageserholungsstätten) for children and adults.

As a large majority of the sanatoria are located outside of heavily bombed cities, and as many homes for tuberculosis-infected adults and children are easily convertible into emergency sanatoria, the most pressing needs for tuberculosis beds can probably be met during the transition period.

The fact that a variety of agencies own the available institutional facilities, and the further fact that admission to many of the institutions is restricted to specific groups -- such as persons eligible for social insurance -- should be no obstacle to their general utilization in a period of emergency. The law concerning unification of health administration makes the health officer (Amtsarzt) the chairman of the local association that includes all groups active in the field of tuberculosis control, and thus paves the way for adoption of policies keyed to the needs of the time. (See TUBERCULOSIS CONTROL.)

TYPHOID FEVER (Typhus).

Typhoid fever is notifiable throughout the Reich. Reported cases numbered 4,856 in 1930; 3,193 in 1935;

9,163 in 1940; 7,723 in 1941; 16,403 in 1942; and 18,581 in 1943. During the war, the morbidity rate per 100,000 persons has risen markedly. By 1942, it had become about four times as high as in 1935. To judge from the rather inadequate information available, it has increased further since that time. A majority of the cases occurred in the annexed territories, in particular in the East. However, serious outbreaks were also admitted in parts of the Old Reich, such as Hamburg and Schleswig-Holstein, and probably occurred in many of the cities in which water supply and sewage disposal were severely damaged.

Deaths from typhoid fever numbered 556 in 1930; 359 in 1935; 971 in 1940; 805 in 1941; and 1,622 in 1942. The case fatality has remained close to 10 percent.

Specific control measures include: (1) immunization, recently stressed in areas with outbreaks; (2) authorization for the health officer (Amtsarzt) to isolate the sick and suspected cases against their will, if necessary; (3) the exclusion from school of sick teachers and pupils, of suspected cases, of carriers (Dauerausscheider), and of persons living in a household with a typhoid fever case; (4) readmission to school of persons who have been sick only after three negative stool and urine tests

(Stuhl- und Urinuntersuchungen) taken at 8-day intervals, and of carriers only on the basis of a certificate from the health officer; (5) the exclusion of typhoid carriers from any occupation in the food industry (Lebensmittelindustrie), in certain types of food trade, such as butchershops (Metzgereien) and bakeries (Bäckereien), and in the production and distribution of milk if this involves contact with the product; and (6) authorization for the health officer to forbid fairs (Messen), public markets (Öffentliche Märkte), and public meetings in places where typhoid is epidemic.

TYPHUS FEVER (Fleckfieber).

Typhus fever is reportable throughout the Reich. Prior to the war only a few sporadic cases were observed. In the years from 1930 to 1939, a total of 13 cases were reported. Since 1940 there has been a wide and continuous spread of the disease, beginning in the eastern parts of Germany and gradually affecting many other sections of the country. Significantly, the publication of official statistics on typhus fever was suddenly discontinued. This fact supports the assumption that the number of cases actually reached several thousand in 1942, as various

estimates had it. It is not quite certain to what extent foreign workers and native population were stricken but it is probable that persons belonging to the first group were the principal victims.

This increase is due to introduction of the disease primarily from Poland, one of the principal foci of typhus fever, which experienced a severe epidemic in 1942.

With growing louse infestation (Verlausung), epidemics of typhus fever are becoming more than a remote possibility, particularly if mass movements of civilians or soldiers are carried out without prior delousing.

The specific control measures actually applied include (1) the use of louse-repellent powder; (2) vaccination with anti-typhus vaccine, of which there seems to be a shortage; (3) delousing in special facilities (Entlausungsanstalten) connected with showers; and (4) hospitalization in special units.

VENEREAL DISEASES (Geschlechtskrankheiten).

Venereal diseases as such are not reportable. Reporting is obligatory, however, in the following specific cases (1) if a patient in the infectious stage of a venereal disease discontinues treatment or observation by a physician (wenn der Kranke sich der Ärztlichen Behandlung oder Beobachtung entzieht), and (2) if a patient, by reason of his occupation or personal conduct, especially endangers other persons (wenn der Kranke andere infolge seines Berufs oder seiner persönlichen Verhältnisse besonders gefährdet). To obtain information on the incidence of venereal diseases, nation-wide surveys by the census method were taken in 1927, 1934, and 1940. The results of the first two studies have been published in full detail, but not those of the 1940 survey.

The incidence of new cases of venereal disease declined from an estimated number of 372,000 cases, or 580 per 100,000 population, in 1927 to an estimated number of 225,300, or 343 per 100,000 population, in 1934. By this achievement, the value of the nation-wide control program set up by the Weimar Republic early in 1927 was convincingly proved. (See VENEREAL DISEASE CONTROL). Despite these successful efforts, venereal diseases

continued to rank first in frequency among all communicable diseases -- with the possible exception of measles -- and because of their effect on individual and public health constituted the major health problem in pre-war Germany.

Some of the findings of the 1934 census have general significance, and may well serve to guide future policy. Cases of acute gonorrhea (akuter Tripper) occurred at the rate of 361 per 100,000 men and 129 per 100,000 women, or 242 per 100,000 population. They constituted nearly four-fifths of all new cases of venereal disease among men and more than half of all those among women. Cases of chronic gonorrhea (chronischer Tripper) formerly not treated came to the attention of physicians at the rate of 17 per 100,000 men and 29 per 100,000 women. Proportionately, chronic gonorrhea accounted for less than 4 percent of all new venereal disease cases among men, but for as much as 12 percent of those observed among women.

Cases of primary syphilis (Syphilis or Lues) occurred at the rate of 24 per 100,000 men and 7 per 100,000 women, while the rates of secondary syphilis were 21 and 28 for 100,000 men and women respectively. Proportionately, primary and secondary syphilis constituted about 10 percent of all venereal disease cases

among men and about 15 percent of those among women.

The figures for congenital syphilis (angeborene Syphilis) were 5 and 7 new cases per 100,000 male and female persons respectively. Finally, there were 21 and 29 cases of latent syphilis (ruhende Syphilis) per 100,000 men and women respectively. They accounted for about 5 percent of all venereal disease cases among men and nearly 13 percent among women.

Large cities showed a very high frequency of venereal diseases -- more than half of all new cases were reported from these areas -- while small towns with 10,000 to 20,000 inhabitants had the lowest proportion. Exceeding the average by far were the port cities of Hamburg, Lübeck, and Bremen, and the areas of Mecklenburg, Anhalt, and Saxony. The age groups primarily afflicted were those between 15 and 35 years, and among them the age groups from 20 to 24 and from 25 to 29 were leading. A substantial proportion of all cases occurred among girls between 15 and 19. Significantly, a considerable proportion of the sick -- about one-fourth -- were married persons.

In the five years following this survey the situation has not changed significantly, although the

1940 census figures indicate a further decline in the incidence of syphilis. However, the official statistics -- even if one assumes the accurate compilation of available data -- cannot possibly have been based on source material as complete and accurate as that of earlier studies.

To judge from general experience, a marked increase in venereal diseases must be anticipated after the war. The particular dangers that must be faced are a relatively high incidence of acute gonorrhea and much chronic gonorrhea among women. With the restoration of the original control program and a large-scale application of modern treatment, it should be possible soon to reduce the number of infectious cases of gonorrhea. Contrary to earlier experience, considerable infection of people in rural areas must be expected.

VENEREAL DISEASE CONTROL (Bekämpfung der Geschlechtskrankheiten).

By the Reich law of 18 February 1927, a nationwide program of venereal disease control was established. Its basic idea was to substitute a health service available to everybody for a system of police regulation of

prostitution. (See PROSTITUTION.) Most of the provisions of the 1927 law have been continued by the Nazi regime, some have been modified, and some abandoned. Following is a summary of the program for venereal disease control, giving the principles adopted by the Weimar Republic as well as the changes made by the Nazi regime.

(1) Every individual who knows, or should be expected to know, that he or she has a venereal disease in an infectious stage is required to seek medical treatment, whether the patient is male or female, adult or minor, rich or poor (allgemeine Behandlungspflicht für jede Person, die an einer mit Ansteckungsgefahr verbundenen Geschlechtskrankheit leidet). This requirement applies to syphilis (Syphilis), gonorrhea (Tripper), and chancroid (Schanker), regardless of place of manifestation or stage.

(2) Everybody has the right to obtain medical care at public expense, if necessary. A great majority of the German population is protected by compulsory sickness insurance. Insured persons are entitled to complete medical care under their respective programs but may, if they so desire for personal reasons, receive

treatment at public expense. Furthermore, every person ineligible for social insurance service may obtain medical care for venereal disease from public agencies, if he or she cannot pay the full costs. Such persons are called persons with limited means (minderbemittelt) and must not be confused with the indigent. Their eligibility is determined by the health department. Persons without resources of their own, the Hilfsbedürftigen, are eligible for public medical care as a matter of right under the Reich decree concerning public assistance. (See WELFARE, PUBLIC.) There is no recovery of cost from persons treated at public expense, if to apply such a policy would be "unreasonable" (unbillig).

(3) The services available to the patient include all diagnostic services; treatment by specialists as well as general practitioners; care at the home, office, clinic, or hospital; and necessary drugs. Amount and period of service are not limited. Some of the diagnostic and treatment methods are applicable only with the consent of the patient.

(4) The treatment of venereal diseases and of any disease or abnormal condition of the sex organs (Krankheiten oder Leiden der Geschlechtsorgane) is the exclusive

responsibility of physicians. In other words, non-medical practitioners are strictly excluded from any service directly or indirectly related to venereal disease control, a policy called Aufhebung der Kurierfreiheit. Treatment by mail order (Fernbehandlung), and advertising (Anpreisen) of drugs, methods or devices directly or indirectly referring to venereal disease are forbidden.

(5) Case finding and prevention of transmission of infection are attained by a series of legal measures. Any person definitely suspected of being sick and transmitting a venereal disease (Personen, die dringend verdächtig sind, geschlechtskrank zu sein und die Geschlechtskrankheit weiterzuverbreiten) is subject to supervision by the health authority (Gesundheitsbehörde), which since 1940, has been the health department. This measure applies to men as well as women and to promiscuous persons as well as commercial prostitutes. These persons must submit a medical certificate (Ärztliches Gesundheitszeugnis) if there are good reasons to assume that they are sources of infection as defined above. Originally emphasis was placed on utilizing designated physicians, primarily specialists, for the purpose of certification. Lately, this function may have been shifted to the personnel of the health department, although the situation is not clear.

The health department has power to order treatment against the will of the patient (Zwangsbehandlung) and to hospitalize and detain patients, if this is deemed necessary for prevention of the spread of disease (wenn dies zur Verhütung der Ausbreitung der Krankheit erforderlich erscheint). Routine examination of prostitutes, abolished by the law of 1927 because of its glaring defects, was reintroduced by the Nazi regime about 1940 -- the examination to be taken once a week -- and these women were again supplied with the notorious control-book (Kontrollbuch) giving evidence of their "supervision". Any physician attending patients with venereal disease is obliged to report those sick in an infectious stage who discontinue treatment or observation (Kranke, die sich der ärztlichen Behandlung oder Beobachtung entziehen), and also those who, by reason of occupation or personal conduct, especially endanger other persons (Kranke, die andere infolge ihrer Berufs oder ihrer persönlichen Verhältnisse besonders gefährden). Furthermore, the physician must try to determine the source of infection (Feststellung der Infektionsquelle) and make sure that treatment is sought, or else report to the health department. Finally, the physician must instruct each patient individually on the nature of

his disease, its implications, and the provisions of the law, and must give him a printed leaflet with a digest of pertinent information. Sexual intercourse and marriage during the infectious stage are punishable offenses (verboten). The law concerning the protection of marriage (Ehegesundheitsgesetz) requires a health certificate for any person engaged to marry, and makes persons with infectious diseases ineligible for a marriage license. Thus, premarital serological examination, although not required explicitly, is demanded by implication. Since 1940, concealment of a former syphilitic infection has been a valid cause for divorce (Scheidungsgrund). Other punishable offenses are the breast-feeding (Stillen) of a well child by a woman with venereal disease, the breast-feeding of an infant with congenital syphilis by a person other than his mother, the breast-feeding of an infant with a venereal disease other than syphilis without prior medical advice, and the placing of a child with venereal disease with foster parents (Inpflegegabe) without prior advice on the situation. This means that health certificates are required for wet-nurses (Ammen), infants to be attended by wet-nurses, and children to be placed in foster homes. Prophylactics (Schutzmittel) against

venereal diseases are legally allowed to be sold, provided they are not publicly advertised or exhibited in an indecent manner. A number of large cities used to distribute prophylactics free of charge through their first-aid stations (Rettungsstellen). Lately, however, most of the mechanical protectors (Gummiüberzüge) have been banned, since they also serve the purpose of contraception.

(6) To carry out the control program, the local authorities are required to provide hospitals, clinics, and professional services, as needed. For hospitalization, the facilities of general hospitals are used preferably and widely, while a few special hospitals are maintained for detention purposes. Clinics (Beratungsstellen) serve primarily the purposes of establishing the diagnosis, case-finding, and follow-up. Some are maintained by the administration of pension insurance (Invalidenversicherung) while others are supported by public agencies. The health department has to see to it that a sufficient number is available in its district. Treatment outside of hospitals is usually given by physicians in private practice, and occasionally also by public clinics. The sickness insurance system pays

for the medical care of a large majority of the people. Responsibility for meeting the costs of the tax-supported services is vested in large administrative units, the Landesfürsorgeverbände. (See WELFARE, PUBLIC.)

(7) The administration of the venereal disease control program is centralized in the health department, which keeps records on promiscuous persons endangering others, has power to issue orders, and supervises facilities and personnel participating in the program. A special agency, the Pflegeamt, is responsible for social work as an integral part of the total program. The police authorities are responsible for the enforcement of the statutes concerning prostitution (see PROSTITUTION), and for assistance to the health department in carrying out its orders, including the patrolling of streets and restaurants. Their powers have been strengthened by the Nazi regime because of assertedly shocking conditions on the streets.

(8) Information on sex problems (sexuelle Belehrung) was a routine procedure in the large majority of public schools at the time of the Weimar Republic, but seems to have been curbed since 1933. Instruction in biology usually included information on sex questions, and classes

graduating from high schools, vocational schools or similar institutions were addressed by physicians on the specific problem of venereal disease. Saxony (Sachsen) was one of the administrative units which paid particular attention to the development of such practices. In 1930, it issued a decree requesting the school authorities to lend full assistance to the health departments in promoting sex education.

Since 1902, the German Association for the Campaign against Venereal Diseases has been highly active in developing sound attitudes toward venereal disease, promoting sex education, and influencing public policy. It is now one of the members of the Reich Advisory Council on Public Health.

VISITING NURSE (Gemeindeschwester).

The visiting nurse's primary function is bed-side nursing of the sick in the home. Health education and medical social work are the functions of specially trained women, the Gesundheitsfürsorgerinnen or Gesundheitspflegerinnen. (See PUBLIC HEALTH NURSE.) In small communities and rural areas, the Gemeindeschwester plays a most important role, as she carries much of the

responsibility for emergency service and the care of minor illness and also participates in preventive health work. She is equipped with a first-aid kit and equipment for disinfection, and in remote areas also with emergency drugs.

Visiting nurse service is operated mainly by non-governmental organizations. Usually it is organized on a geographical basis, with one full-time nurse assigned to a specified area. Sectarian as well as non-denominational nurses can be found in a given section of the country. In some parts of the country, such as Bavaria (Bayern), Catholic nurses predominate; in others nurses affiliated with Protestant organizations are numerous. The National-Socialist welfare organization (N.S. Volkswohlfahrt) has placed much emphasis on the development of visiting nursing by non-denominational personnel trained to spread the party gospel along with nursing. Before the war, the number of visiting nurse centers (Gemeindeschwesternstationen) was in the neighborhood of 14,000.

The social insurance organizations have long made it a practice to subsidize visiting nurse service, and public agencies have followed the same policy. The

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sickness insurance organizations not infrequently pay for care given to the insured, and occasionally also for service to family dependents.

WATER SUPPLY (Wasserversorgung).

According to various estimates, 77.2 percent of the water is groundwater (Grundwasser), 14.2 percent surface water (Oberflächenwasser) and 8.6 percent spring water (Quellwasser). Before the war, about 70 percent of the population was served by central piped water distribution systems (zentrale Wasserversorgung). This means that not only city populations but also many people in small communities had access to service, as less than 60 percent of the population lived in places with more than 15,000 inhabitants. Wells (Brunnen) were used to some extent in cities, and widely in rural areas. Under normal conditions there was no shortage of domestic water supply, although some cities had to augment overtaxed groundwater supplies by using surface water. Industrial water supply, however, has always presented problems in some areas, and this situation has been aggravated by the demands of war economy. Widely accepted standards call for 150 liters of water per person per day in cities over 100,000 population, 80 to 120 liters in smaller cities depending on the size of the population, and 50 liters in rural communities (plus 50 liters per head of cattle).

Water is treated (Wasserbearbeitung) primarily for the removal of excess minerals, such as iron, calcium salts, and magnesium salts, and for bacterial purification (Beseitigung von Bakterien). The principal methods used are rapid and slow filtration (Filtration or Filterung), chemical treatment, including chlorination (Chlorung), and aeration. Prior to the war, most of the piped water supply could be used without further treatment. The war has altered and dislocated normal practices of extraction, purification, and distribution, creating a water supply of questionable safeness throughout the country. A shortage of essential chemicals has led to the discontinuation of chlorination in a number of communities. A recent decree permitted the introduction of untreated water into the distribution system. Furthermore, increased use of water taken from individual wells has been encouraged, despite the fact that many are in bad repair or exposed to contamination from sewage receptacles.

In general, cities and towns, and also many counties, own and operate their own waterworks (Wasserwerke). Often a number of small communities have assumed joint responsibility for such works by forming Zweckverbände. Industrial

water supply is not infrequently organized under private auspices. The health officer (Amtsarzt) is charged by law with ensuring adequate hygienic standards for drinking water (Trinkwasser). Recommendations as to standards are contained in (1) Anleitung für die Einrichtung, den Betrieb und die Überwachung öffentlicher Wasserversorgungsanlagen, published in Veröffentlichungen des Reichsgesundheitsamtes 1906, and (2) the Prussian Hygienische Leitsätze für die Trinkwasserversorgung.

An important factor in the organization and administration of the water supply is the Wasser- und Bodenverband, composed of property owners, associations of individuals, public law corporations etc. Such Verbände are responsible for drinking water supply and many other aspects of water supply. Their functions and powers are defined in the Gesetz über Wasser- und Bodenverbände of 10 February 1937.

WEIL'S DISEASE (Weilsche Krankheit).

Weil's disease, caused by Leptospira icterohaemorrhagica, is notifiable throughout the Reich. Reported cases numbered 84 in 1940; 90 in 1941; and 103 in 1942. Deaths from this disease were given as 17 in 1940; 17

in 1941; and 5 in 1942.

Official statistics obviously do not include cases of infectious hepatitis, although they use the term Weil's disease and infectious jaundice (*icterus infectiosus*) alternately. According to German statements, infectious hepatitis has become very common during the war, exactly as during the First World War. The disease is said to have been introduced from Eastern areas. Its course seems to be mild.

WELFARE, PRIVATE (Private Wohlfahrtspflege).

Non-governmental welfare organizations have long shared in the establishment and maintenance of institutional facilities such as general and special hospitals (see HOSPITAL), in the professional education and support of certain types of health personnel, particularly nurses and Gesundheitsfürsorgerinnen, and in the provision of medical care to the needy. Some of these organizations, mainly the Jewish and those sponsored by organized labor, have been abolished by the Nazi regime. Among the survivors are (1) the Innere Mission, an organization of the Protestant church, and (2) the Deutscher Caritasverband, an organization of the Catholic church, both of which have maintained

a semblance of independence; and (3) the Deutsches Rotes Kreuz (see GERMAN RED CROSS) which has developed virtually into a party agency. To take the wind out of the sails of private welfare organizations, the Nazi regime devoted much effort to the promotion of a National-Socialist welfare organization, the N. S. Volkswohlfahrt, which penetrated deep into the fields formerly cultivated by private welfare. Visiting nursing, maternal and child health, convalescent care, and recreation have especially and increasingly become spheres of Party influence.

WELFARE, PUBLIC (Offentliche Wohlfahrtspflege).

Public welfare activities in Germany rest on two nation-wide laws: (1) the Reich decree of 13 February 1944 concerning public assistance (Reichsverordnung über die Fürsorgepflicht), and (2) the Reich law of 9 July 1922 concerning child welfare (Reichsjugend-wohlfahrtsgesetz). Both statutes have been frequently amended, and supplemented by many rules and regulations. They are important to the health administrator not only because they are the basis of nation-wide public welfare activities designed to provide the needy (die Hilfs-

bedürftigen) with the necessities of life, but also because they complement the system of health services, including the services available under social insurance.

The Reich decree concerning public assistance -- and in particular the supplementary principles of 4 December 1924 concerning the prerequisites, type, and scope of public assistance (Reichsgrundsätze Über Voraussetzung, Art und Mass der Öffentlichen Fürsorge) as amended -- make it mandatory for public agencies to provide the necessities of life for specified groups of persons in need. Several categories of persons in need are accorded a preferred status (Gehobene Fürsorge), recipients of pensions from social insurance constituting the largest single group. All other persons in need are eligible for general relief (Allgemeine Fürsorge, formerly called Armenfürsorge).

Prerequisite to obtaining public aid is economic need as proved through a means test (Prüfung der Hilfsbedürftigkeit). The right of the needy to receive public assistance includes the right to obtain (1) medical care (Krankenhilfe) in case of illness from injury or disease and in maternity (Wochenfürsorge); and (2) aid for rehabilitation. Costs of maternity service, of

rehabilitation of the blind, deaf-mute and crippled, and of services for children under 18 years are not recoverable, and costs of treatment for venereal disease or tuberculosis are recoverable only if this is not "unreasonable" (unbillig).

Responsible for execution of the law are special administrative bodies: the Landesfürsorgeverbände which generally comprise the territory of a state or a large unit such as the province, and the Bezirksfürsorgeverbände which generally cover the area of a city or county (Stadtkreis, Landkreis). The Landesfürsorgeverbände in addition to being in charge of general policy and supervision of local agencies, are responsible for the maintenance and administration of hospitals and related institutional facilities for the mentally sick, mentally defective, deaf-mute, blind and crippled; for support of public programs of aid to the tuberculous and medical care for patients with venereal disease; and for financial assistance to local agencies. Bezirksfürsorgeverbände have primary responsibility for the provision of public aid to the needy, financial support of the services, and administration of the program except for administration of certain institutional facilities.

Welfare departments (Wohlfahrtsämter) are part of the administrative structure at the local and higher levels of government. They receive technical advice and assistance in regard to health matters from the health department (Gesundheitsämter).

The Reich law concerning child welfare declares the protection of foster children (Schutz der Pflegekinder), of children under guardianship (Vormundschaft), and of neglected and delinquent children to be obligations (Pflichtaufgaben) of local units of government. In addition, the law authorizes measures for the welfare of women in maternity, infants, pre-school children, school children, and youths no longer attending school. The term welfare is used in a broad sense.

Administrative responsibility for the child welfare program is vested in child welfare departments (Jugendämter). There is one child welfare department in each local unit of government, i.e., the city (Stadtjugendamt) and county (Kreisjugendamt), while Landesjugendämter are at the state or provincial levels. In a number of instances general welfare and child welfare departments are unified. Health aspects of the child welfare program are under the administrative control of the health department

(Gesundheitsamt), with the health officer (Amtsarzt) acting as consultant to the child welfare department.

WHOOPING COUGH (Keuchhusten).

Whooping cough is notifiable throughout the Reich.

Reported cases numbered 133,479 in 1940; 107,543 in 1941; 88,306 in 1942; and 129,395 in 1943. The frequency of this disease was highest in infancy.

Deaths from whooping cough totalled 3,603 in 1930; 1,820 in 1935; 1,373 in 1940; 1,335 in 1941; and 1,028 in 1942. From these figures it can be concluded that whooping cough mortality per 100,000 has tended to decline probably as a result of improvements in therapy. In the 1940's, the average case fatality was in the neighborhood of 1 percent. It was relatively high in the first year of life.

Persons suffering from whooping cough, or living in a household with a case of this disease are excluded from kindergarten, school, and similar institutions. They are readmitted only after medical examination has established the absence of danger of transmission.

GERMAN - ENGLISH DICTIONARY
of Common Technical Terms

Abbreviations (Abkürzungen)

adj. adjective (Eigenschaftswort)
f. substantive of the feminine gender (weibliches Hauptwort)
m. substantive of the masculine gender
 (männliches Hauptwort)
n. substantive of the neuter gender (sächliches Hauptwort)
pl. plural (Mehrzahl)
v. verb (Zeitwort)

A

Abfallbeseitigung, f.	garbage and refuse disposal
Abfalleimer, m.	garbage pail
Absitzbecken, n.	sedimentation tank
Absiebungsanlage, f.	facility for mechanical clarification of sewage
Absonderung, f.	isolation
Abtreibung, f.	abortion
Abwasserbeseitigung, f.	sewage disposal
Abwasserreinigung, f.	sewage treatment
Abwasser-Reinigungsanlage, f.	sewage treatment plant
Abwehrkraft, f.	vital resistance
Akte, f.	file, dossier
Altersaufbau, m.	age distribution
Alterspension, f.	old-age pension

Altersschwäche, f.	old-age infirmity
Alterssichtigkeit, f.	presbyopia
Ambulatorium, n.	group clinic
Amme, f.	wet nurse
Amöbenruhr, f.	amebic dysentery
Amtsarzt, m.	health officer
Anschlagsäule, f.	bill-board
Anstaltsentbindung, f.	hospital delivery
Anstaltsleiter, m.	hospital director
ansteckend, adj.	infectious
Ansteckung, f.	infection
Ansteckungsgefahr, f.	danger of infection
anzeigepflichtig, adj.	reportable
Apotheke, f.	pharmacy
Apotheker, m.	pharmacist
Arbeiter, m., ausländischer, adj.	foreign worker
Arbeitsamt, n.	employment agency
Arbeitsgemeinschaft, f.	working association, joint working committee
Arbeitslosenunterstützung, f.	unemployment compensation
Arbeitsunfähigkeit, f.	incapacity for work
Arbeitsvermittlung, f.	job placement
Armenfürsorge, f.	general relief
Arznei, f.	drug

Arzneibuch, n.	pharmacopoea
Arzneifertigware, f.	patent medicine
Arzneimittelverkehr, m.	drug trade
Arzt, m.	physician
Arzt, m., dirigierender, adj.	division chief in a hospital
Arzt, m., leitender, adj.	medical director of hospital
Arztregister, n.	register of physicians
Arztwahl, f., freie, adj.	free choice of physician
Augenheilanstalt, f.	eye hospital
Augenkrankheit, f.	eye disease
Augentripper, m., der Neugeborenen, pl.	ophthalmia neonatorum
Ausgrabung, f.	exhumation
Aussatz, m.	leprosy
Ausschlag, m.	exanthema, rash

B

Badeanstalt, f.	bathing facility
Bandwurm, m.	Taenia, usually <i>T. solium</i> or <i>T. saginata</i>
Bangsche Krankheit, f.	Bang's disease
Basedowsche Krankheit, f.	Basedow's disease
Beerdigung, f.	interment
Behandlung, f.	treatment

Beitrag, m.	contribution
Bekämpfung, f., von Krankheiten	disease control
Beobachtung, f.	observation
Beratungsstelle, f.	preventive clinic
Berufsberatung, f.	vocational guidance
Berufsgericht, n.	professional court
Berufskrankheit, f.	occupational disease
Besichtigung, f.	inspection
Bestallung, f.	appointment
Bestrahlung, f., mit künstlicher, adj., Hōhensonnen, f.	radiation by ultra-violet lamp
Betäubungsmittel, n.	narcotic drug
Betriebsarzt, m.	industrial physician
Betriebsunfall, m.	work accident
Bevölkerung, f.	population
Bevölkerungspolitik, f.	population policy
Bezirkshebamme, f.	district midwife
Bissverletzung, f.	bite
Bleivergiftung, f.	lead poisoning
Blennorrhœ, f.	ophthalmia neonatorum
Bordell, n.	brothel
Brausebad, n.	bathing facility with showers
Brunnen, m.	well

C

Chefarzt, m.	medical director of hospital
Chinin, n.	quinine
Chirurgie, f.	surgery
Chlorung, f.	chlorination
Cholera, f.	cholera

D

Dauerausscheider, m.	germ carrier
Dentist, m.	dental technician
Desinfektion, f.	disinfection, extermination
Desinfektion, f., laufende, adj.	current disinfection
Desinfektor, m.	disinfector
Diphtherie, f.	diphtheria
Diphtherieschutzimpfung, f.	diphtheria immunization
Drogerie, f.	drugstore
Durchleuchtung, f.	fluoroscopic examination
Durchmesser, m.	diameter

E

Eheschliessung, f.	marriage
Ehestandsdarlehen, n.	marriage loan
Ehetauglichkeit, f.	fitness for marriage
Einäscherung, f.	cremation
Empfängnisverhütung, f.	contraception

Entbindung, f.	delivery
Entbindungsabteilung, f.	obstetrical division in a hospital
Entbindungsanstalt, f.	maternity hospital
Entlausung, f.	delousing
Entwanzung, f.	extermination of bedbugs
Epidemie, f.	epidemic
Erbkrankheit, f.	hereditary illness
erblich, adj.	hereditary
Erholungsheim, n.	convalescent home
Erkältung, f.	common cold
Erkrankungshäufigkeit, f.	morbidity
Erkrankungsziffer, f.	morbidity rate
Erlaubnis, f.	permit
Ermittlung, f., der Krankheit, f.	epidemiological investiga- tion
Ernährung, f.	nutrition
Ernährungslage, f.	nutritional status
Ernährungsstörung, f.	nutritional disturbance
Erstimpfung, f.	smallpox vaccination
Erwerbsfähigkeit, f.	ability to earn a living

F

Facharzt, m.	specialist
Facharztanerkennung, f.	certification as specialist

Fadenwurm, m.	Enterobius vermicularis
Familienangehörige, pl.	family dependents
Feuerbestattung, f.	cremation
Filterung, f.	filtration
Filzlaus, f.	pubic louse (<i>phthirus pubis</i>)
Fischteich, m.	fish pond
Fleckfieber, n.	typhus fever
Fleischvergiftung, f.	meat poisoning
Forschung, f.	research
Frauenschule, f., soziale, adj.	school of social work
Friedhof, m.	cemetery
Friseurgeschäft, n.	barbershop
Frühgeburt, f.	premature birth
Frühsterblichkeit, f., der Säuglinge, pl.	mortality in early infancy
Fürsorge, f., öffentliche, adj.	public assistance
Fürsorgestelle, f.	preventive clinic
Fürsorgerin, f.	social worker

G

Gasbrust, f.	pneumothorax
Gasleitung, f.	gas main
Gebührentarif, m.	fee schedule

Geburt, f.	birth
Ceburtenregelung, f.	birth control
Geburtenüberschuss, m.	excess of births over deaths
Geburtenziffer, f.	birth rate
Geburtshelfer, m.	obstetrician
Geburtshilfe, f.	obstetrics, obstetrical service
Geburtsverletzung, f.	birth injury
Geheimmittel, n.	patent medicine without declaration as to composition
Gehirnentzündung, f., übertragbare, adj.	epidemic or lethargic encephalitis
Geisteskrankheit, f.	mental disease
Gelbfieber, n.	yellow fever
Gelbsucht, f., ansteckende, adj.	infectious hepatitis
Geldleistung, f.	cash benefit
Gemeindekrankenpflege, f.	visiting nurse service
Gemeindeschwester, f.	visiting nurse or district nurse
Cenehmigung, f.	permit
Genesungsheim, n.	convalescent home
Genickstarre, f., übertragbare, adj.	epidemic meningitis
Geschlechtskrankheit, f.	venereal disease

Geschlechtsorgan, n.	sex organ
Geschlechtsverkehr, m.	sexual intercourse
Geschlechtsverkehr, m., wahlloser, adj.	promiscuity
Geschwür, n.	ulcer
Gesundheit, f.	health
Gesundheitsamt, n.	health department
Gesundheitsaufseher, m.	health inspector
Gesundheitsbehörde, f.	health authority
Gesundheitsfürsorge, f.	preventive health service
Gesundheitsfürsorgerin, f.	nurse-social worker
Gesundheitsgesetzgebung, f.	health legislation
Gesundheitspflegerin, f.	nurse-social worker
Gesundheitspolizei, f.	health police
Gesundheitszeugnis, n., ärztliches, adj.	medical certificate
Gewerbe, n.	trade
Gewerbearzt, m.	industrial physician in public administration
Gewerbehygiene, f.	industrial hygiene
Gewerbe-Unfallversicherung, f.	industrial accident insurance
Gewichtsverlust, m.	weight loss
Gift, n.	poison
Crippe, f.	influenza
Grobrechen, m.	coarse (bar) screen

Grundwasser, n.	ground water
H	
Hackfleisch, n.	chopped meat
Hafenarzt, m.	port health officer
Halsentzündung, f., eitriga, adj.	septic sore throat
Haltungsfehler, m.	faulty posture
Hausarzt, m.	family doctor
Hausentbindung, f.	delivery in the home of the patient
Hausgehilfin, f.	domestic servant
Hauskläranlage, f.	septic tank installed in dwellings
Hauspflegerin, f.	housekeeping aide
Hauterkrankung, f.	skin disease
Hauttuberkulose, f.	skin tuberculosis
Hebamme, f.	midwife
Hebammenlehrlanstalt, f.	training school for midwives
Heilgehilfe, m.	medical attendant
Heilpraktiker, m.	non-medical practitioner
Heilstätte, f.	tuberculosis sanatorium
Heilstättenbehandlung, f.	treatment in a Tb sanatorium
Heil- und Pflegeanstalt, f.	mental hospital

hilfsbedürftig, adj.	needy
Hilfspersonal, n., Ärztliches, adj.	auxiliary health personnel
Hilfsschulkind, n.	mentally backward child
Höhenonne, f., künstliche, adj.	ultra-violet lamp
hörschwach, adj.	hard of hearing
Hygiene, f.	hygiene

I

Impfarzt, m.	physician in charge of smallpox vaccination
Impfpflicht, f.	requirement of smallpox vaccination
Impftermin, m., Öffentlicher, adj.	public vaccination clinic
Infektionskrankheit, f.	communicable disease
Infektionsquelle, f.	source of infection
Invalidenpension, f.	permanent disability pension
Invalidenversicherung, f.	workmen's pension insurance
Invalidität, f.	permanent disability
Irrenanstalt, f.	mental hospital

J

Jugendamt, n.	child welfare department
Jugendgericht, n.	juvenile court
Jugendwohlfahrt, f.	child welfare

K

Kammerjäger, m.	exterminator
Kanalisation, f.	water-carriage sewerage system
Kassenarzt, m.	insurance practitioner
Kassendentist, m.	dental technician in insurance practice
Kassenzahnarzt, m.	insurance dentist
Kehlkopftuberkulose, f.	laryngeal tuberculosis
Keimgehalt, m.	bacterial count
Keimträger, m.	germ carrier
Keuchhusten, m.	whooping cough
Kieferkrankheit, f.	jaw disease
Kindbettfieber, n.	puerperal fever
Kinderarbeit, f.	child labor
Kinderbeihilfe, f.	family allowance
Kinderkrankenhaus, n.	children's hospital
Kinderkrankheit, f.	children's disease
Kinderlähmung, f., epidemische, adj.	poliomyelitis, epidemic
Kläranlage, f.	sewage clarification facility
Kleiderlaus, f.	body louse
Kleinkinderberatungstelle, f.	pre-school child health clinic
Kleinstallung, f.	small stable

Knappschaftsversicherung, f.	miners' insurance
Körnerkrankheit, f.	trachoma
Kontrollbuch, n.	control book (of prostitutes)
Konzession, f.	license
Kopflaus, f.	head louse
Krankenbeförderung, f.	ambulance service
Krankengeld, n.	disability compensation
Krankenhaus, n.	hospital
Krankenhaus, n., allgemeines, adj.	general hospital
Krankenhaus, n., städtisches, adj.	municipal hospital
Krankenhilfe, f.	medical care for persons covered by social insurance
Krankenkasse, f.	agency administering sickness insurance
Krankenpfleger, m.	nurse (male)
Krankenschwester, f.	nurse (female)
Krankenversicherung, f.	sickness insurance
Krankenversicherung, f. private, adj.	voluntary sickness insur- ance
Krankenwagen, m.	ambulance
Krankheit, f.	disease
Krankheit, f., Über- tragbare, adj.	communicable disease
Krankheitsverdacht, m.	suspected case of disease

Krebs, m.	cancer
Kreiskrankenhaus, n.	county hospital
Kriegsbeschädigter, m.	war veteran
Kriegsgefangener, m.	war prisoner
Krippe, f.	crèche, day nursery
Kropf, m.	goiter
Krüppelfürsorge, f.	crippled children's program
Krüppelfürsorgestelle, f.	crippled children's clinic
Krüppelheilanstalt, f.	orthopedic hospital
Krüppelstammliste, f.	masterfile of crippled children
Küchenabfälle, m., pl.	kitchen waste
Kurzsichtigkeit, f.	myopia

L

Landapotheke, f.	rural pharmacy
Laus, f.	louse
Lebendgeburt, f.	live birth
Lebendgeburtenziffer, f.	live birth rate
Lebensmittelchemiker, m.	food chemist
Lebensmittelindustrie, f.	food industry
Lebensmittelkontrolle, f.	food control

Lebensmittelvergiftung, f.	food poisoning
Lebensmittelvergiftung, f. bakterielle, adj.	bacterial food poisoning
Leibesübungen, f. pl.	physical education
Leichenöffnung, f.	autopsy
Leichenwesen, n.	disposal of the dead
Lepra, f.	leprosy
Letalität, f.	case fatality
Lichtbehandlung, f.	light therapy
Lues, f.	syphilis
Lumpenhandel, m.	rag trade
Lungenentzündung, f.	pneumonia
Lungenkrankheit, f.	pulmonary disease
Lungentuberkulose, f.	pulmonary tuberculosis

M

Magen-Darmkrankheit, f.	gastrointestinal disease
Malaria, f.	malaria
Masern, f., pl.	measles
Medizinaluntersuchungsamt, n.	public health laboratory
Medizinisch-technische Assistentin, f.	laboratory technician
Mehrleistung, f.	optional benefit under social insurance
meldepflichtig, adj.	reportable

Milchflasche, f.	milk bottle
Milchwagen, m.	milk wagon
Milzbrand, m.	anthrax
minderbemittelt, adj.	a person with small resources
Müllabfuhr, f.	collection and disposal of garbage and refuse
Mülleimer, m.	rubbish can
Müllwagen, m.	garbage truck
Mundkrankheit, f.	mouth disease
Muskelrheumatismus, m.	muscle rheumatism
Mütterberatungsstelle, f.	infant health center
Müttererholungsfürsorge, f.	convalescent care of women after delivery
Mütterfürsorge, f., gesundheitliche, adj.	maternal health service
Mütterheim, n.	maternity home
Mütter- und Säuglingsheim, n.	home for mother and child
N	
Nachfüllung, f.	refill
Nachuntersuchung, f.	re-examination
Nahrungsmittelchemiker, m.	food chemist
Nervenkrankheit, f.	(1) neurosis, (2) neurological condition
Niederlassungserlaubnis, f.	permit to practice

Notkrankenhaus, n. emergency hospital

Notschlachtungsfleisch, n. meat from diseased animals

O

Oberarzt, m. senior resident in a hospital

Oberflächenwasser, n. surface water

Ofen, m. stove

Ohrenkrankheit, f. ear disease

Orthopädie, f. orthopedics

P

Papageienkrankheit, f. psittacosis

Paratyphus, m. paratyphoid fever

Pasteurisierung, f. pasteurization

Pensionsversicherung, f. pension insurance

Pest, f. plague

Pflegeanstalt, f. chronic disease hospital

Pflegeeltern, pl. foster parents

Pflegekind, n. foster child

Pocken, f. pl. smallpox

Pockenschutzimpfung, f. smallpox vaccination

Pockenwiederimpfung, f. smallpox revaccination

Poliklinik, f. out-patient department

Privatklinik, f.	proprietary hospital
Prostitution, f.	prostitution
Prüfung, f., staatliche, adj.	state board examination
Pumpstation, f.	pumping station

Q

Quellwasser, n.	spring water
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R

Rachitis, f.	rickets
Rassenhygiene, f.	racial hygiene
Rechtsberatung, f.	legal advice
Regelleistung, f.	statutory benefit under social insurance
Reglementierung, f.	regulation of prostitution
Reichsarztregister, n.	national register of physicians
Reichsgesundheitsamt, n.	Reich health office
Reihenuntersuchung, f.	medical examination of all persons in a certain age group, occupation, etc.
Rentenempfänger, m.	recipient of social insurance pension
Rentenversicherung, f.	pension insurance
Rettungsstelle, f.	first-aid station
Rettungswache, f.	first-aid station
Rettungswesen, n.	first-aid service

Rieselfeld, n.	sewage farm
Röntgenbild, n.	x-ray picture
Röntgenuntersuchung, f.	x-ray examination
Rohr, n.	pipe
Röteln, pl.	German measles
Rotz, m.	glanders
Rückfallfieber, n.	relapsing fever
Ruhr, f.	dysentery

S

Sanitätsoffizier, m.	medical corps officer, armed forces
Säuglingsfürsorge, f.	infant health service
Säuglingsfürsorgestelle, f.	infant health clinic
Säuglingskrankenhaus, n.	babies' hospital
Säuglingssterblichkeit, f.	infant mortality
Säuglings- und Kinder- Krankenhaus, n.	children's hospital
Säuglings- und Kinder- schwester, f.	children's nurse
Schanker, m.	chancroid
Scharlach, m.	scarlet fever
Schlaganfall, m..	apoplexy
Schlamm, m., aktivierter, adj.	activated sludge
Schlammzersetzung, f.	sludge digestion
Schlussdesinfektion, f.	terminal disinfection
Schulzarzt, m.	male school physician

Schulärztin, f.	female school physician
Schulgesundheitspflege, f.	school health service
Schulgesundheitsschein, m..	child health card
Schulschwester, f.	school nurse
Schulspeisung, f.	school breakfast or lunch
Schulzahnarzt, m.	school dentist
Schulzahnklinik, f.	dental clinic for school children
Schulzahnpflege, f.	school dental program
Schutzimpfung, f.	immunization
Schutzkleidung, f.	protective clothing
Schwachsinn, m.	feeble-mindedness
Schwachsinnigenanstalt, f.	institution for mental defects
Schwangerenfürsorgestelle, f.	prenatal clinic
Schwangerschaft, f.	pregnancy
Schwester, f.	female nurse
Schwimmbad, n.	swimming pool
sehschwach, adj.	(a person) with defective vision
Sepsis, f.	septicemia
Sicherheitsingenieur, m.	safety engineer
Siechenhaus, n.	chronic disease hospital
Silikose, f.	silicosis
Skrofeln, f. pl.	scrofulosis

Sozialversicherung, f.	social insurance
Sozialversicherungsträger, m.	any agency administering social insurance
sprachgestört, adj.	(a person) with speech defect
Spulwurm, m.	<i>Ascaris lumbricoides</i>
Staatsbeamter, m.	civil servant of the State
Stadtgesundheitsamt, n.	municipal health department
Standesamt, n.	Registrar's office
Statistik, f.	statistics
Staublungenerkrankung, f.	pneumoconiosis
Sterbefall, m.	case of death
Sterbegeld, n.	funeral benefit under social insurance
Sterbeziffer, f.	mortality rate
Sterblichkeit, f.	mortality
Stillgeld, n.	nursing allowance
Stoffwechselkrankheit, f.	metabolic disease
Strassenkehricht, m.	street refuse
Sucht, f.	addiction
Syphilis, f.	syphilis
Syphilis, f., angeborene, adj.	congenital syphilis
Syphilis, f., ruhende, adj.	latent syphilis

T

Tafelwasser, n.	mineral water
Tageserholungsstätte, f.	day camp
Tauglichkeit, f., körperliche, adj.	physical fitness
Tiefkühlung, f.	refrigeration
Tierarzt, m.	veterinarian
Todesfall, m.	case of death
Todesursache, f.	cause of death
Tollwut, f.	rabies
Totgeburt, f.	still birth
Totgeburtenziffer, f.	still birth rate
Trichinenschau, f.	examination of meat for trichinæ
Trichinose, f.	trichinosis
Trinkerheilanstalt, f.	institution for treatment of alcoholics
Trinkwasser, n.	drinking water
Tripper, m.	gonorrhea
Tropfkörper, m.	trickling filter
Tuberkulose, f.	tuberculosis
Tuberkulosefürsorgestelle, f.	tuberculosis clinic
Tuberkulosekrankenhaus, n.	tuberculosis hospital
Tularämie, f.	tularemia
Typhus, m.	typhoid fever

U

"Übergangsrente, f.	temporary pension
übertragen, v.	to transmit
"Übertragung, f.	transmission
Überwachung, f., gesundheitliche, adj.	health supervision
unehelich, adj.	illegitimate
Unfall, m.	accident
Unfallverhütung, f.	accident prevention
Unfallversicherung, f.	accident insurance
Unfruchtbarmachung, f.	sterilization
Universitätsklinik, f.	teaching hospital affiliated with university
Unsauberkeit, f.	uncleanliness
Unterleibstyphus, m.	typhoid fever
Untersuchungsamt, n.	public health laboratory
Untersuchungsanstalt, f., chemische, adj.	chemical laboratory
Unzucht, f.	fornication

V

Verbrennung, f.	incineration
vererblich, adj.	hereditary
Vergiftung, f.	poisoning

Verkehr, m., mit Arzneimitteln	drug trade
Verkehrsunfall, m.	traffic accident
Verkrüppelung, f.	crippling condition
Verlausung, f.	infestation with lice
Verletzung, f.	injury
Versicherungspflicht, f.	requirement to be insured
Versorgungswesen, n., ärztliches, adj.	medical care of war veterans
Vertrauensarzt, m.	supervising physician
Verwaltung, f.	administration
Verwurmung, f.	helminthiasis
Volksbelehrung, f. gesundheitliche, adj.	health education
Vorbeugung, f.	prevention

W

Wasserbearbeitung, f.	water treatment
Wasser- und Bodenverband, m.	water and land association
Wasserleitung, f.	water pipe
Wasserversorgung, f.	water supply
Wasserversorgung, f., zentrale, adj.	central piped water distribution system
Wasserwerk, n.	waterworks
Wechselfieber, n.	malaria

Weilsche Krankheit, f.	Weil's Disease
Wiederimpfung, f.	revaccination
Windpocken, f. pl.	chickenpox
Wochenfürsorge, f.	maternity service for needy persons
Wochengeld, n.	maternity benefit under social insurance
Wochenhilfe, f.	maternity service for persons covered by social insurance
Wochenpflegerin, f.	child-bed attendant
Wohlfahrtsamt, n.	welfare department
Wohlfahrtsarzt, m.	welfare physician
Wohlfahrtspflege, f., Öffentliche, adj.	public welfare
Wohlfahrtspflege, f., private, adj.	private welfare
Wunde, f., eiternde, adj.	purulent wound
Nurmkrankheit, f., der Bergleute	Ancylostoma
Wutschutzstation, f.	Pasteur institute

Z

Zahnarzt, m.	dentist
Zahnarztregister, n.	register of dentists
Zahnföhule, f.	dental caries

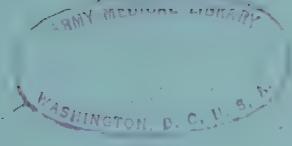
Zahnpflege, f.	dental care
Ziegenpeter, m.	mumps
Zuckerkrankheit, f.	diabetes
Zwangsbehandlung, f.	compulsory treatment
Zwangskrankenversicherung, f.	compulsory sickness insurance

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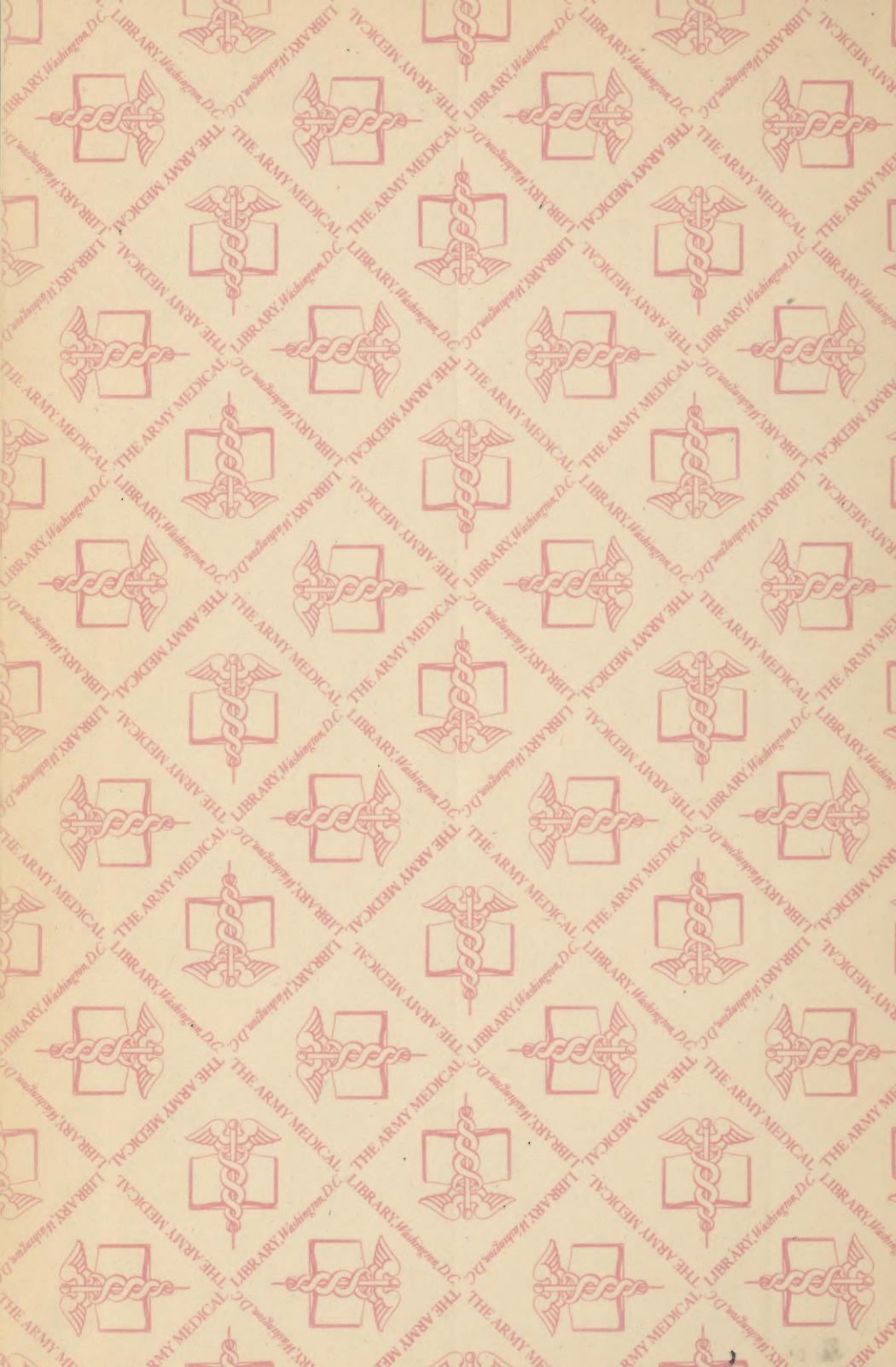
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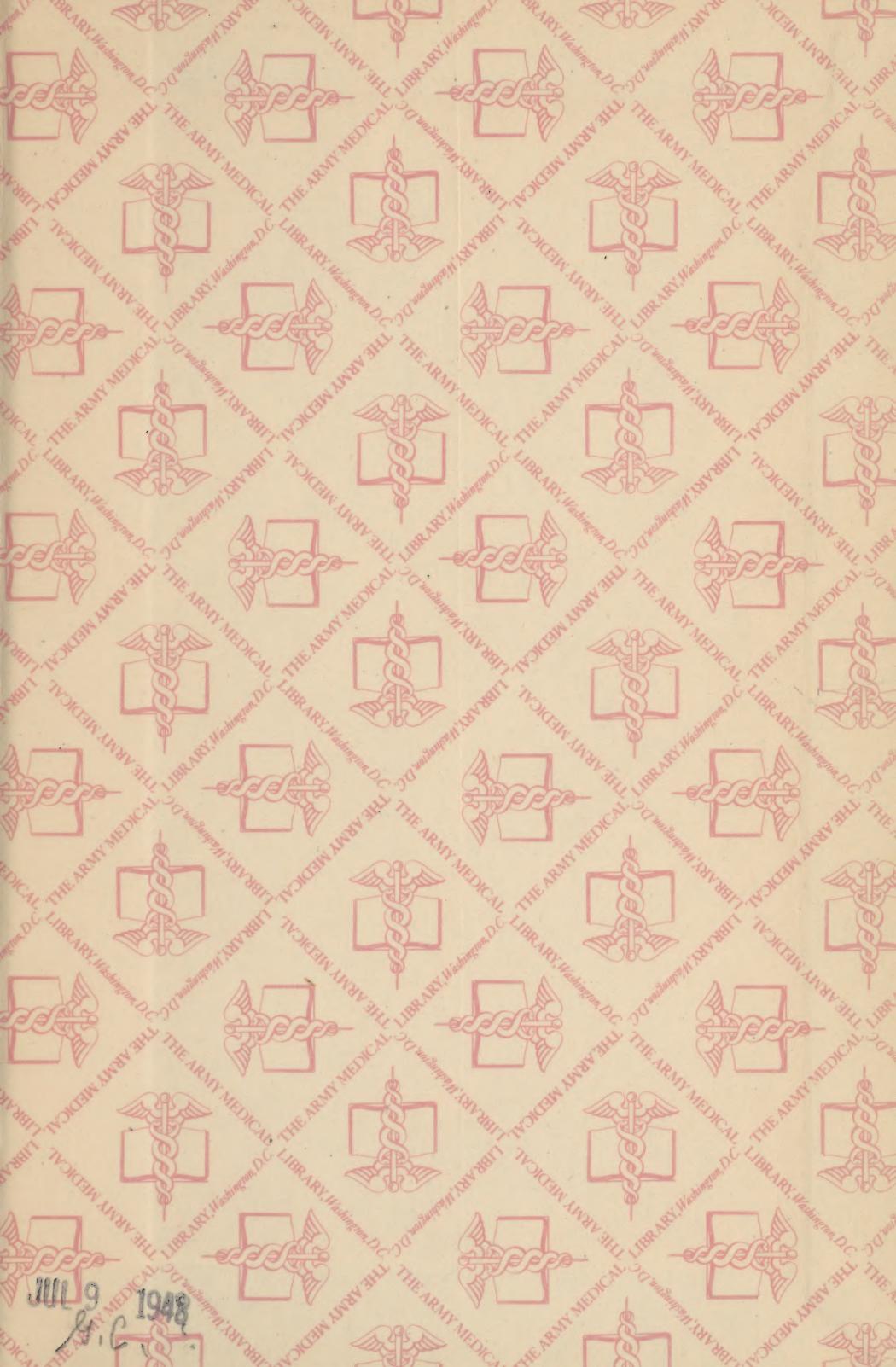
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